

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 2017

HEARINGS BEFORE A SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS HOUSE OF REPRESENTATIVES ONE HUNDRED FOURTEENTH CONGRESS SECOND SESSION

SUBCOMMITTEE ON THE DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES

TOM COLE, Oklahoma, Chairman

MICHAEL K. SIMPSON, Idaho	ROSA L. DELAURU, Connecticut
STEVE WOMACK, Arkansas	LUCILLE ROYBAL-ALLARD, California
CHARLES J. FLEISCHMANN, Tennessee	BARBARA LEE, California
ANDY HARRIS, Maryland	CHAKA FATTAH, Pennsylvania
MARTHA ROBY, Alabama	
CHARLES W. DENT, Pennsylvania	
E. SCOTT RIGELL, Virginia	

NOTE: Under Committee Rules, Mr. Rogers, as Chairman of the Full Committee, and Mrs. Lowey, as Ranking Minority Member of the Full Committee, are authorized to sit as Members of all Subcommittees.

SUSAN ROSS, JOHN BARTRUM, JENNIFER CAMA,
JUSTIN GIBBONS, KATHRYN SALMON, and LORI BIAS,
Subcommittee Staff

PART 5

	Page
Department of Health and Human Services	1
Corporation for National and Community Service	185
Substance Abuse and Mental Health Services Administration	223
Department of Labor	295



Printed for the use of the Committee on Appropriations

U.S. GOVERNMENT PUBLISHING OFFICE

COMMITTEE ON APPROPRIATIONS

HAROLD ROGERS, Kentucky, *Chairman*

RODNEY P. FRELINGHUYSEN, New Jersey	NITA M. LOWEY, New York
ROBERT B. ADERHOLT, Alabama	MARCY KAPTUR, Ohio
KAY GRANGER, Texas	PETER J. VISCLOSKY, Indiana
MICHAEL K. SIMPSON, Idaho	JOSE E. SERRANO, New York
JOHN ABNEY CULBERSON, Texas	ROSA L. DELAURO, Connecticut
ANDER CRENSHAW, Florida	DAVID E. PRICE, North Carolina
JOHN R. CARTER, Texas	LUCILLE ROYBAL-ALLARD, California
KEN CALVERT, California	SAM FARR, California
TOM COLE, Oklahoma	CHAKA FATTAH, Pennsylvania
MARIO DIAZ-BALART, Florida	SANFORD D. BISHOP, JR., Georgia
CHARLES W. DENT, Pennsylvania	BARBARA LEE, California
TOM GRAVES, Georgia	MICHAEL M. HONDA, California
KEVIN YODER, Kansas	BETTY MCCOLLUM, Minnesota
STEVE WOMACK, Arkansas	STEVE ISRAEL, New York
JEFF FORTENBERRY, Nebraska	TIM RYAN, Ohio
THOMAS J. ROONEY, Florida	C. A. DUTCH RUPPERSBERGER, Maryland
CHARLES J. FLEISCHMANN, Tennessee	DEBBIE WASSERMAN SCHULTZ, Florida
JAIME HERRERA BEUTLER, Washington	HENRY CUELLAR, Texas
DAVID P. JOYCE, Ohio	CHELLIE PINGREE, Maine
DAVID G. VALADAO, California	MIKE QUIGLEY, Illinois
ANDY HARRIS, Maryland	DEREK KILMER, Washington
MARTHA ROBY, Alabama	
MARK E. AMODEI, Nevada	
CHRIS STEWART, Utah	
E. SCOTT RIGELL, Virginia	
DAVID W. JOLLY, Florida	
DAVID YOUNG, Iowa	
EVAN H. JENKINS, West Virginia	
STEVEN M. PALAZZO, Mississippi	

WILLIAM E. SMITH, *Clerk and Staff Director*

DEPARTMENTS OF LABOR, HEALTH AND HUMAN SERVICES, EDUCATION, AND RELATED AGENCIES APPROPRIATIONS FOR 2017

THURSDAY, FEBRUARY 25, 2016.

BUDGET HEARING—DEPARTMENT OF HEALTH AND HUMAN SERVICES

WITNESS

HON. SYLVIA BURWELL, SECRETARY, DEPARTMENT OF HEALTH AND HUMAN SERVICES

OPENING STATEMENT

Mr. COLE. Good morning, Madam Secretary. It is my privilege to open up the hearing.

I just want to begin by telling you what a personal pleasure it is to have you here, and I mean that with all sincerity. I think you have—you are an exceptional public servant in your skill and your dedication and your bipartisanship.

And so I look forward to working with you. We will certainly have some, you know, challenging questions for you this morning on both sides of the aisle, as we always do. But again, I know how seriously you approach the job and the effort that you put in, and I appreciate it personally very, very much.

So my pleasure again to welcome you to the Subcommittee on Labor, Health and Human Services, and Education for our first hearing of the year. Looking forward to hearing your testimony.

Madam Secretary, your responsibilities are many. There are many things in your budget that I think we can all agree are priorities and that we can collectively support. There are other areas we may disagree upon. The challenge that we'll be facing this subcommittee is how we can support the most critical programs and make the very best use of every taxpayer dollar entrusted to us.

Unfortunately, your budget assumes many areas of tax increases, new user fees, changes in mandatory spending, and other spending sources that are beyond the purview of this subcommittee. I was especially disappointed to see your proposal to cut the National Institutes of Health.

Your proposal to divert \$1,000,000,000 of biomedical research funds to the mandatory side of the budget ledger and rely on new and perhaps unlikely authorizations to continue the advances we have made in increasing research funding were disheartening to me.

I look forward to having a discussion with you this morning on the impact of these proposed cuts. I will also be asking some tough questions this morning about the ongoing management challenges at HHS. Problems of substandard quality in hospitals within the Indian Health Service and a continued slow-walking of investigations into alleged violation of the law as it relates to conscience protections continue to concern me greatly. I hope to learn more this morning on what you are doing to take positive steps in these areas.

Finally, we are all keenly aware of the many external challenges facing your agency. The worldwide concern surrounding the Zika virus is but the latest example of this, and I hope you will be able to update us on this situation today as well.

As a reminder to the subcommittee and our witnesses, we will abide by the 5-minute rule so that everyone will have a chance to get their questions asked and answered.

Before we begin, I would like to yield the floor to my good friend from Connecticut, my ranking member, Ms. DeLauro.

OPENING STATEMENT

Ms. DELAUR. Thank you very much, Mr. Chairman.

Can I first say that this is very impressive, the dais and the high-tech communication. But I am looking around the room and the redo here, I like it, but it is very beige, Mr. Chairman, and—but it is good. It looks good. It has got a nice tone to it.

I deal with a little bit more color, but it is very good. It is calming. So, anyway, thank you again, Mr. Chairman.

Madam Secretary, welcome back to the Labor, HHS Subcommittee. I believe it is exactly one year to the day since you last appeared here. I, too, want to express my gratitude for the great work that you do and the commitment that you have to the mission of health and human services, but also your commitment to this country and making sure that people are well taken care of.

I want to thank the chairman. I think together we were able to make many great investments in the labor, health and human services bill last year. In many ways, last year's omnibus moved the Federal budget in the right direction, began to leave behind the shortsighted policies of austerity that have slowed our economic recovery. We made real progress on funding for NIH research, the antibiotic resistant bacteria initiative, medical countermeasures, and access to high-quality early childhood education.

I do continue to be disappointed that we did not do better for other programs under the subcommittee's jurisdiction, and I am troubled that the labor, HHS bill received only a fraction, about one-half, of its fair share of the \$66,000,000,000 increase provided by last year's budget deal. While the other non-defense subcommittees received an average increase of 6.9 percent last year, the labor, HHS bill increased by only 3.4 percent. In my view, that needs to change this year.

One year ago, we were in the midst of a worldwide response to the Ebola outbreak in West Africa. Now we find ourselves confronting two public health crises, the Zika virus and the tragedy in Flint.

First, the Zika virus, which may be causing thousands of babies in Latin America to be born with severe birth defects, is infecting travelers returning to the United States and is even being transmitted sexually. We should act quickly on the administration's request for emergency supplemental appropriations to defend against this serious threat.

Some of my colleagues have expressed a desire to shift unobligated funds that Congress provided for Ebola to respond to Zika. I strongly oppose that idea. The threat of Ebola is not over. I would be anxious to know what activities we would have to forego if we shift funds away from Ebola to Zika.

We need to be able to respond to multiple health threats at the same time, and Congress must act quickly to protect Americans from the Zika virus.

At the same time, HHS is the lead Federal agency on the ground in Flint, Michigan, where we have learned that thousands of children have been exposed to lead poisoned water for more than a year. Not only did the State of Michigan fail to protect its people from lead poisoning, the Government created this crisis and magnified its effects with delayed response.

I will just give you—this is from an article dated 9/25/05. This is Katrina. The reporter is Michael Ignatieff at Harvard. He said, "The broken contract, it was not blacks or the poor, but citizens whom the Government betrayed in New Orleans."

One can make the same application here, and he says, "A contract of citizenship defines the duties of care that a public official owes to the people of a democratic society. It is a tacit understanding that citizens have about what to expect from their government. Its basic term is protection, helping citizens to protect their families and possessions from forces beyond their control."

When the State made the decision to turn off the spigot and turn it on in the Flint River, they broke that contract with the people, and now it is our responsibility to provide people with the kinds of help that they need in order that they may succeed.

It is imperative that we resolve the crisis immediately, provide health and education interventions that these children and their families will need going forward. And it is my hope that the State, the administration, and the Congress will do that.

These emergencies demonstrate that our Federal system needs to respond more rapidly as threats arrive, which is why this Congress and last Congress, I proposed funding the Public Health Emergency Fund to enable the Federal Government to immediately respond to public health threats. It is modeled on the Disaster Relief Fund, which we have, which is \$8,000,000,000.

It enables a rapid Federal response following a natural disaster. If we can act quickly to respond to floods, fires, other natural disasters, we should be able to act quickly to respond to public health emergencies.

We also need to strengthen our investments in HHS programs through annual appropriations, which brings me to the topic of today's hearing, your budget, HHS budget request for fiscal 2017.

I strongly believe, as you know, that programs in the HHS budget are among the most important responsibilities that the Federal Government has. They support lifesaving research, State and local

public health infrastructure, community health centers, and home heating assistance for low-income families. Literally, you work at saving lives.

Madam Secretary, there are a lot of good proposals in this budget. Particularly, I applaud the President for his continued commitment to Head Start, child care, and preschool. I will say that I was disappointed to see cuts to cancer screenings and public health programs at the CDC and that funding for HIV research remains level at \$3,000,000,000 for 2016 and 2017.

I am also concerned that other important programs rely on mandatory funding. The budget includes \$1,800,000,000 in mandatory funding for NIH research, \$115,000,000 in mandatory funding to support early interventions for individuals with serious mental illness, and \$500,000,000 in mandatory funding to help individuals who are addicted to prescription drugs and opioids.

We need to increase this committee's allocation. That is the answer to this issue, to support NIH research, to address the opioid epidemic in this country, rather than relying on mandatory funding that may not materialize, which is why the subcommittee allocations that will be released next month will be so critically important. And I hope my colleagues on my side of the aisle and on the other side of the aisle will join us in making sure that we have an increase for Labor, HHS in 2017.

And that is for the good of the children and good of the families that depend on these services. We need to make an increase in this allocation a priority.

Thank you very much for being here and I look forward to the discussion and your testimony.

Mr. COLE. Thank you very much.

Ms. DELAUR. Thank you, Mr. Chairman.

Mr. COLE. But before we begin with your testimony, we have been joined by our ranking member, Mrs. Lowey from New York. So I certainly want to recognize her for any opening remarks she would care to make.

Mrs. LOWEY. And I want to thank Chairman Cole, my good friend, and my good friend Rosa DeLauro for your hard work on this committee. It has been an honor for me to be part of this committee for a long time, for almost my whole congressional career, and we know how important this is.

And this may be your last occasion to testify before this committee, and I want to first thank you for your service as Director of OMB, now as Secretary of Health and Human Services. And I must say if every person in Government would put their heart and soul and their brains to work the way you do, we would move forward much more quickly.

So I really do want to thank you very much. It has been a pleasure for me to work with you and to know you.

Now in terms of the substance, with recent emerging threats, your remaining year as Secretary will not be easy. Our mission to eradicate Ebola is not yet complete. New outbreak of dangerous diseases such as Zika are pushing Federal public health infrastructure resources to the breaking point. Congress has a request for supplemental funding to combat Zika. I urge this committee, and Congress as a whole, to meet this need without delay.

While outbreaks require significant attention, we cannot turn our backs to manmade public health emergencies at home, and I struggle to find the words to describe the criminal incompetence that jeopardize thousands of American citizens in Flint, Michigan. I look forward to hearing about actions the department is taking in co-ordinating the Federal response to address the short-term and long-term healthcare needs that will be required.

It is truly amazing to me because this is an issue I have been working on, again, for a very long time, and how this could have been ignored, the incompetence of the officials involved is really quite extraordinary. So I am hoping we can take action very quickly.

The budget request includes increases for vitally important initiatives such as early childhood education, biomedical research, substance abuse treatment and prevention. As an appropriator, the department's requests for substantial sums in mandatory funding is of concern, particularly the fact that without this mandatory request, your budget amounts to a decrease in discretionary funding of 1.5 percent.

With that said, there are significant improvements that I would like to highlight. One of the major obstacles to economic security for low-income working Americans is access to affordable, high-quality child care and early learning, such as Head Start. While this committee has increased funding for these initiatives in recent years, we are not meeting our commitment to the public.

In fact, the value of Federal funding for child care has lagged well behind inflation and increases in child care cost. As a result, the Federal share for child care has decreased by approximately 20 percent since 2003. And there are more than 14 million American children that are eligible for child care subsidies, yet only 15 percent receive Child Care and Development Fund assistance.

These funding constraints do not exist in a vacuum, and by not making investments in child care, hard-working parents may have to reduce their hours, leave their jobs altogether, or delay education programs that could allow them to invest in their family's economic security.

An increase of \$201,000,000 for child care is desperately needed, but this alone will not be enough. Federal support for child care and early learning programs for low-income Americans must be increased nationwide to meet this demand and chart our children on a path to success from an early age.

Your budget includes targeted investments in biomedical research, which, to me, must continue to be a top priority. And I was so pleased with the work of this committee increasing the money for the National Institutes of Health. The Cancer Moonshot is very exciting, increases in the BRAIN Initiative that will deepen our understanding of the human brain to combat diseases and disorders, including Alzheimer's, Parkinson's, and autism. These investments not only fund research that eases suffering for patients, they could greatly reduce ballooning costs associated with treatment down the line.

So, again, thank you for your leadership, and thank you to the chair and our ranking member for your important work on this bill, and I look forward to your testimony.

Thank you, Mr. Chairman.

Mr. COLE. Thank you. It is always a pleasure when our good friend is able to join us.

And with that, Madam Secretary, the committee would love to hear your testimony.

OPENING STATEMENT

Secretary BURWELL. Great. Thank you so much.

Mr. Chairman, Ranking Member DeLauro, Mrs. Lowey, and members of the committee, I want to thank you all for this opportunity to discuss the budget of the Department of Health and Human Services.

I think, as many of you know, I believe that all of us share common interests, and therefore, we can find common ground. And last legislative session, as has been mentioned, this Congress made timely investments in programs to improve the health and welfare of the American people, and thank you for the role that you all played in that.

The budget before you today is the final budget for this administration and my final budget. It makes critical investments to protect the health and well-being of the American people. It helps ensure that we can do our job to keep people safe and healthy.

It accelerates our progress in scientific research and medical innovation and expands and strengthens our healthcare system, and it helps us continue to be responsible stewards of the taxpayer dollars. For HHS, the budget proposes \$82,800,000,000 in discretionary budget authority.

Our request recognizes the constraints in our budget environment and includes targeted reforms to Medicare, Medicaid, as well as other programs. Over the next 10 years, these reforms to Medicare could result in a net savings of \$419,000,000,000.

Let me start with an issue that we have been working on here at home and abroad, and as we work aggressively to combat the spread of Zika, the administration is requesting \$1,900,000,000 in emergency funding, including \$1,500,000,000 for HHS to enhance our ongoing efforts, both domestically and internationally. We appreciate Congress' consideration of this important request as we implement essential strategies that are time-sensitive to prevent, detect, and respond to this virus.

I know the rise in opioid misuse and abuse and overdose has affected many of your constituents. Every day in America, 78 people are dying of opioid-related deaths, and that is why this budget proposes a significant increase in funding, over \$1,000,000,000, to fight the opioid epidemic.

Research shows that early learning programs can set a course for a child's success throughout his or her life, and that is why over the course of this administration, and together with congressional support, we have more than doubled access to Early Head Start and services for infants and toddlers. Our budget proposes an increase of \$434,000,000 for the Head Start program and an investment in child care services that would allow us to serve over 2.6 million children.

Today, too many of our Nation's children and adults with diagnosable mental health disorders don't receive the treatment

that they need. So the budget proposes \$780,000,000 in new mandatory and discretionary resources over the next 2 years to try and close this gap.

While we invest in the safety and health of Americans today, we must also relentlessly push forward on the frontiers of innovation and research. Today, we are entering a new era in medical science. With a proposed increase of \$107,000,000 for the Precision Medicine Initiative and \$45,000,000 for the administration's BRAIN Initiative, we continue that progress.

But for all Americans to benefit from these breakthroughs in medical science, we need to ensure that all Americans have affordable healthcare. And the Affordable Care Act has made progress, historic progress, in that space. Today, more than 90 percent of Americans have health coverage. That is the first time in our Nation's history that that has happened.

The budget seeks to build on that progress by improving the quality of care that patients receive, spending our health dollars more wisely, and putting an engaged, empowered, and educated consumer at the center of their care. By advancing and improving the way we pay doctors, the way we coordinate care and use health data and information, we can build a system that is better, smarter, and healthier.

Finally, I just want to thank the employees of HHS. In the past year, they have helped end the Ebola outbreak in West Africa. They have advanced the frontiers of medical science. They have helped millions of Americans enroll in health coverage and have just done the day-to-day quiet work that makes our Nation healthier and stronger, and I am honored to be a part of that team.

As members of this committee, I think, know, I personally am committed to working with you all closely, with you and your staff, to find common ground so that we can deliver impact for the American people. And with that, I welcome your questions.

Thank you.

[The prepared statement and biography of Secretary Burwell follow:]

Statement by
Sylvia M. Burwell
Secretary
U.S. Department of Health and Human Services
on
The President's Fiscal Year 2017 Budget
before
Committee on Appropriations
Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

U.S. House of Representatives
February 25, 2016

Chairman Cole, Ranking Member DeLauro, and Members of the Committee, thank you for the opportunity to discuss the President's FY 2017 Budget for the Department of Health and Human Services (HHS). In FY 2016, the Congress made timely investments in programs to improve the health and welfare of American citizens, such as programs to address opioids abuse and expanding access to health care centers and Head Start. The FY 2016 appropriation also made important investments in many research frontiers like precision medicine and research to combat antibiotic resistant bacteria. We thank you for your leadership on these important issues and look forward to building on these investments in FY 2017.

The Department has made historic strides towards ensuring that all Americans have access to the building blocks of healthy and productive lives—a priority that I know we share. Thanks to the Affordable Care Act, we have helped millions of Americans find quality, affordable insurance, and slowed the growth in health care costs for families and taxpayers. At the same time, we have worked to improve the quality of coverage—with more protections and benefits, like wellness visits and some cancer screenings now offered at no extra cost—no matter where you get your insurance. Alongside this work, we have responded to a number of national and global health

challenges. In coordination with our partners across the federal government, we led a response to the Ebola outbreak in West Africa and prepared our infrastructure here at home, and have helped to unite global health leaders to prevent and respond to future outbreaks. We convened state leaders in our fight against prescription drug abuse as part of a nationwide three-pronged strategy to drive progress. And we advanced the frontier of medicine through cutting-edge research in genomics and technology. Through all these efforts, we have worked to ensure the responsible stewardship of taxpayer dollars by taking steps to further strengthen program integrity, saving money for the taxpayer and making sure our programs deliver in the best possible way for those we serve.

The President's FY 2017 Budget for HHS builds on this progress through critical investments in health care, science and innovation, and human services. The Budget proposes \$82.8 billion in discretionary budget authority, and additional mandatory funding to further support specific initiatives in the discretionary budget. This includes investments in critical priorities that I know we share—cancer research, opioids abuse prevention and treatment, and behavioral health efforts. The Budget recognizes our continued commitment to balancing priorities within a constrained budget environment through legislative proposals that, taken together, would save on net an estimated \$242 billion over 10 years.

Building upon the Successes of the Affordable Care Act

The FY 2017 Budget advances access, affordability, and quality in our nation's health care system—goals that we share with Congress and this Committee. Through targeted investments,

the Budget expands access to care, particularly for rural and underserved populations, and supports primary and preventive care.

Investing in Health Centers. For 50 years, health centers have delivered comprehensive, high-quality, cost-effective primary health care to patients regardless of their ability to pay. Today, more than 1,300 health centers operate over 9,000 sites and provide health care services to 1 in 14 people in the United States, including to over 175,000 patients at 89 centers in Oklahoma and 330,000 patients at 237 centers in Connecticut. Health centers also play a role in reducing the use of costlier care through emergency departments and hospitals. The Budget invests \$5.1 billion in health centers, including \$3.75 billion in mandatory resources, to serve over 27 million patients across the country in FY 2017.

Increasing Access to Health Care for Minority and Underserved Populations. The Department is investing in several initiatives that will improve access to care for underserved groups across the United States, including those living in rural areas. We know that this is a priority for many of you on this Committee. The Budget includes investments of nearly \$14 billion over ten years in our Nation's health care workforce to improve access to healthcare services, particularly in rural and other underserved communities. This includes support for over 10,150 National Health Service Corps clinicians serving the primary care, mental health and dental needs of more than 10.7 million patients in areas with limited access to care. The request includes additional funding to place providers in rural areas and other underserved communities in order to expand access to treatment for prescription opioid and heroin abuse and to improve access to crucial mental and behavioral health services. In addition, the Budget will allow the Health Centers

Program to serve an estimated 9.7 million rural Americans, an increase of approximately 1.5 million more rural patients than are served today.

The Department also takes steps to close health disparities for minorities and Native Americans. The FY 2017 Budget provides an estimated \$13 billion, a \$382 million increase above FY 2016, for programs and services to improve the health of minority communities and reduce health disparities. In addition to the investments in the Health Centers Program, where over 60% of patients are from racial or ethnic minorities, the Budget also extends \$14 million in funding for the Health Career Opportunities Program to increase the diversity and cultural competence of the health professions workforce.

The Budget includes \$67 million in new investments in the critical area of behavioral health in tribal communities to address high rates of mental illness, substance abuse, and suicide. It also increases funding for the Indian Health Service by \$402 million to continue progress and reduce health disparities in Indian Country, as well as fully funding contract support costs, which provides critical overhead funding to tribes who operate facilities under self-determination and self-governance agreements. The Budget removes the cap on funding to Medicaid programs in the U.S. territories to better align territory Medicaid programs with those of States and expands eligibility to 100 percent of the Federal poverty level in territories currently below this level. This proposal would gradually increase the share of Medicaid costs covered by the federal government as territories modernize their Medicaid programs—providing critical healthcare funding to Puerto Rico and helping to mitigate the effects of its fiscal crisis.

Expanding Access to Health Insurance Coverage. The Affordable Care Act is expanding access to care for millions of Americans who would otherwise be uninsured, improving quality of care for people no matter how they get their insurance, while slowing the growth in healthcare costs nationwide. To encourage more states to expand Medicaid, the Budget would give any state that chooses to expand Medicaid eligibility three years of full federal support, no matter when the state expands. The Budget also funds the Children’s Health Insurance Program through FY 2019 to ensure comprehensive and affordable coverage for beneficiaries as well as budget stability for states.

Healthcare Delivery System Reform

At HHS, we are focused on moving towards a health care system that delivers better quality of care, spends dollars in a smarter way, and keeps people healthy. The Budget advances the Department’s work in three critical areas: improving the way providers are paid, finding better ways to deliver care, and creating better access to health care information for providers and patients.

Improving the Way Providers Are Paid. Rather than paying for the quantity of tests and screenings that providers order—a common practice—the Department is moving toward paying for the quality of care given. For patients, this can lead to more frequent communication with their care provider and fewer unnecessary trips back to the hospital. The Budget includes proposals to establish competitive bidding for Medicare Advantage payments and introduce value-based purchasing for certain Medicare providers. The Budget also encourages

participation in alternative payment models through a number of proposals, including creating a bonus payment for hospitals that collaborate with certain alternative payment models. The Department has already committed to moving Medicare fee-for-service payments to 30% in alternative payment models by the end of 2016, and 50% by 2018. We believe that we are on track to meet our goal, and look forward to working with Congress to build on this progress.

Improving Care Delivery. To drive progress in the way care is provided, HHS is focused on improving the coordination and integration of health care, engaging patients more fully in decision-making, and improving the health of patients—with an emphasis on prevention and wellness. As part of that, we are focused on improving access to care by investing in and supporting telehealth, especially for rural areas. The Budget proposes to expand the ability of Medicare Advantage plans to deliver services via telehealth, and to enable rural health clinics and federally qualified health centers to qualify as originating telehealth sites under Medicare.

Improving Access to Information. In an effort to promote transparency on price, cost, and billing for consumers, the Budget supports the standardization of billing documents and elimination of surprise out-of-network charges for privately insured patients receiving care at an in-network facility. The Budget also provides continued investments to achieve secure, seamless data interoperability in order to better serve individuals, providers, and payers, including a funding increase and new authorities for the Office of the National Coordinator for Health Information Technology.

Building Evidence to Drive Systemic Improvement. Reforming the delivery system requires an evidence base of effective practices. The Budget proposes an increase of \$24 million for health services research at the Agency for Healthcare Research and Quality (AHRQ) to advance and improve the performance of the healthcare system. For example, AHRQ data show that 87,000 fewer patients died in hospitals due to patient harms from 2010 to 2014—saving nearly \$20 billion. While we are encouraged by this progress, substantial challenges remain to build a health system that meaningfully involves patients in decision making, and consistently uses high quality evidence to provide safe and high quality care for all.

Keeping People Healthy and Safe

The President’s Budget builds on the Department’s strategy to address prescription drug abuse, invests in crucial behavioral health services, and strengthens our nation’s public health infrastructure.

Preventing Prescription Drug Abuse. Prescription drug abuse impacts the lives of millions of people across the country—with 78 Americans dying in opioid-related deaths every single day. The Budget proposes significant new discretionary and mandatory funding totaling nearly \$1.1 billion to build on investments funded by Congress in FY 2016 and to execute on the Department’s three-pronged evidence-based approach to combat the opioids crisis:

- ***Expanding the Use of Medication-Assisted Treatment.*** The new two-year, \$1 billion mandatory funding investment will help ensure that every American who wants to get treatment for an opioid addiction will be able to. These funding levels will enable

individuals with opioid use disorder to get treatment in FY 2017 and FY 2018 by reducing costs, engaging patients, and expanding access to treatment.

- ***Improving Prescribing Practices.*** The Budget invests in programs that support improved prescribing practices, including by supporting improved uptake of CDC’s upcoming prescribing guidelines for providers. The Budget also proposes to require states to track high prescribers and utilizers of prescription drugs in Medicaid—saving \$770 million over 10 years—and bolsters other critical efforts to support providers with the tools they need.
- ***Expanding the Development and Use of Naloxone.*** Responders to an overdose have little time to effectively reverse the effects of an opioid and save a life. To best prepare communities and first responders, the Budget includes a total of \$22 million for programs that support the use of naloxone – a lifesaving overdose reversal drug. Among other critical programs, the Budget invests \$10 million in the Rural Opioid Overdose Reversal Grant program to target rural areas hit hardest by opioid abuse.

Expanding Access to Mental and Other Behavioral Health Care. Despite the expanded behavioral health coverage for millions of Americans by the Affordable Care Act, less than half of children and adults with diagnosable mental health disorders receive the treatment they need. To address this gap, the Budget proposes a total of \$999 million, including a new two-year \$500 million investment in mental health care, to help engage individuals with serious mental illness in care, improve access to care by increasing service capacity through certified community behavioral health clinics, boost the behavioral health workforce, and ensure that behavioral health care systems work for everyone. A portion of the two-year, \$500 million

mandatory initiative will allow six additional states to participate in the Certified Community Behavioral Health Clinic Demonstration—established by section 223 of the Protecting Access to Medicare Act of 2014 under this Committee’s leadership.

Combating Antibiotics Resistant Bacteria. The emergence of antibiotic-resistant bacteria continues to be a significant public health concern. The FY 2017 Budget includes \$877 million to continue expanding the nation’s ability to protect patients and communities by implementing interventions that reduce the emergence and spread of antibiotic-resistant pathogens. This funding will also support ongoing ground-breaking research to aid the development of new drugs and diagnostic products, building the nation’s treatment options for these dangerous pathogens.

Investing in Domestic and International Preparedness. The Department leads critical efforts to strengthen our public health infrastructure here at home and bolster the nation’s preparedness against chemical, biological, nuclear and radiological attacks. The Budget invests \$915 million, an increase of \$2 million, for domestic and international public health infrastructure, including funding to expand implementation of the Global Health Security Agenda (GHSA) to strengthen capacity in Phase 2 countries to address public health emergencies. Over the next five years, the United States will work with more than 30 partner countries—representing over four billion people—to help them prevent, detect, and effectively respond to infectious disease threats. I am pleased to share that work with many of these countries has already begun. We appreciate the funding provided by Congress last year for this crucial priority.

As we work aggressively to combat the spread of Zika, the Administration is requesting more than \$1.8 billion in emergency funding, including \$1.48 billion for HHS, to enhance our ongoing efforts both domestically and internationally. The requested resources will build on our ongoing preparedness efforts and will support essential strategies to combat this virus, such as rapidly expanding mosquito control programs; accelerating vaccine research and diagnostic development; enabling the testing and procurement of vaccines and diagnostics; educating health care providers, pregnant women and their partners; improving epidemiology and expanding laboratory and diagnostic testing capacity; improving health services and supports for low-income pregnant women, and enhancing the ability of Zika-affected countries to better combat mosquitoes and control transmission. We appreciate the Congress's consideration of this important request.

Serving Refugees and Unaccompanied Children. In light of a global displacement crisis, the Administration has committed to expanding the Refugee Admissions Program in FY 2016 and FY 2017. All refugees are subject to the highest level of security checks of any category of traveler to the United States. At HHS, the Administration for Children and Families' role is to link newly-arrived humanitarian populations, including refugees, asylees, Cuban entrants, and special immigrant visa-holders, to key resources necessary to becoming self-sufficient, integrated members of American society. The Budget provides initial financial and medical assistance for an estimated 213,000 entrants, including 100,000 refugees, consistent with the Administration's commitment to admitting at least 100,000 refugees in FY 2017.

In addition to serving the populations discussed above, HHS is also legally required to provide care and custody to all unaccompanied children apprehended by immigration authorities until they are released to appropriate sponsors to care for them while their immigration cases are processed. Based upon the increase in unaccompanied children apprehended at the Southwest border this fall, ACF has taken prudent steps to add temporary capacity so that we are adequately prepared. To ensure that HHS can provide appropriate care for unaccompanied children in FY 2017, the Budget includes the same amount of total base resources available in FY 2016, as well as a contingency fund that would trigger additional resources only if the caseload exceeds levels that could be supported with available funding.

Building Blocks for Success at Every Stage of Life

The Budget request supports the Department's efforts to serve Americans at every stage of life, including by promoting the safety and well-being of our nation's children, and helping older Americans live as independently as possible.

Investing in Child Care and Early Learning. Research has shown the significant positive impact that early learning programs can have on a child's development and lifelong well-being. The Budget proposes strategic investments to make affordable, quality child care available to every low- and moderate-income family with young children; to build on investments to expand access to high quality early learning programs including both Head Start and the newly authorized Preschool Development Grant program; and to invest in voluntary, evidence-based home visiting programs that have long-lasting, positive impacts on child development.

The Administration's investment in Head Start services has more than doubled access for infants and toddlers over the course of the Administration, and significant investments have been made to strengthen the quality of services that Head Start provides. The FY 2017 Budget provides a total of \$9.6 billion for the Head Start program, which includes the resources necessary to maintain this expansion of services. In addition, the Budget builds on the investments made in FY 2016 to expand the number of children attending Head Start programs that offer a full school day and year program, which is proven to be more effective than programs of shorter duration and helps meet the needs of working parents. In collaboration with the Department of Education, the Budget includes \$350 million for Preschool Development Grants to support states in building and expanding high-quality preschool systems.

The President's Budget continues the historic proposal to provide \$82 billion over 10 years in additional mandatory funds for child care to ensure that all low- and moderate-income working families with young children have access to high-quality child care. This proposal will increase the number of children served to a total of 2.6 million by 2026 and raise the quality of care children receive. In addition, the FY 2017 Budget includes almost \$3.0 billion in discretionary child care funding, an increase of about \$200 million, to support states, tribes, and territories as they implement the new health, safety, and quality requirements of the bipartisan child care reauthorization, and to create pilots that will test and evaluate strategies for addressing the child care needs of working families in rural areas and families working non-traditional hours.

Supporting Child Welfare. The Department plays a critical role in supporting child welfare, particularly among vulnerable populations. The Budget includes \$1.8 billion over 10 years to

ensure that child welfare professionals have the right training and skills—proven to be linked to better outcomes for children across a range of measures. The Budget also includes a package of investments designed to do more to prevent the need for foster care and assist children and families so that children can either be reunited with their biological parents or placed in a permanent home.

Supporting Older Adults. As members of this Committee are aware, the population age 65 and over is projected to more than double to 98 million in 2060. In FY 2017, HHS continues to make investments to address the needs of older Americans, many of whom require some level of assistance to live independently and remain in their homes and communities for as long as possible. The Budget continues to propose reforms that help to protect older Americans from identity theft, to support access to counseling, respite, and nutrition services that will allow states to provide approximately 205 million meals to over 2 million older Americans nationwide. The Budget also continues the Department’s commitment to support effective Alzheimer’s disease research, education, and outreach, as well as patient, family, and caregiver services.

Leading the World in Science and Innovation

The FY 2017 Budget builds on the historic gains the Department has made in medical and scientific research and lays the ground work for scientific and technological breakthroughs for the 21st century. Thanks to biomedical research, including NIH investments, cardiovascular death rates in the United States have fallen by more than 70% in the last 60 years. Cancer death rates are now falling 1-2% per year; each 1% drop saves approximately \$500 billion. Breakthroughs in HIV therapies enable people in their 20’s to live a full life span. The FY 2017

Budget includes \$33.1 billion for the NIH, an increase of \$825 million, to build on the funding provided by this Congress in order to advance our shared commitment to support research that promotes economic growth and job creation, and advances public health.

Launching the Cancer Moonshot. Investments in research have led to significant developments in the prevention, screening, and treatment of cancer. To support the Vice President's Cancer Moonshot, the Budget includes a multi-year \$755 million initiative that accelerates the nation's fight against cancer by expanding access to clinical trials, pursuing new vaccine technology, and funding exceptional opportunities in cancer research. These investments will drive scientific advances that aim to understand the causes of cancer, discover new prevention strategies, improve early detection and diagnosis, and develop effective treatments.

Advancing Precision Medicine. Recent breakthroughs in genomics, computing, and molecular medicine have ushered in a new era where more treatments are based on the genetic characteristics of each patient. The Budget increases funding for the Precision Medicine Initiative by \$107 million to a total of \$309 million to support critical new studies on therapies, and to continue to scale a cohort study to gather data on the interplay of environmental exposures, physical parameters, and genetic information.

Investing in the BRAIN Initiative. Despite the advances in neuroscience in recent years, the underlying causes of most neurological and psychiatric conditions remain largely unknown due to the vast complexity of the human brain. To further revolutionize our understanding, the Budget provides an increase of \$45 million, for a total of \$195 million within NIH, for the

BRAIN Initiative. This research has the potential to discover underlying pathologies in a vast array of brain disorders and provide new avenues to treat, cure, and even prevent common conditions, such as Alzheimer's disease, autism, depression, schizophrenia, and addiction.

Making the Department Stronger

One of my top priorities as Secretary is to position the Department to most effectively fulfill its core mission by investing in key management priorities, including program integrity and cybersecurity. I appreciate the Committee's interest in these critical issues.

Strengthening Program Integrity. The Budget continues to make cutting fraud, waste, and abuse a top Administration priority by requesting \$199 million in new program integrity investments in FY 17. The Budget fully funds the Health Care Fraud and Abuse Control (HCFAC) discretionary cap adjustment. In FY 14 alone the HCFAC program returned over \$3.3 billion to the Federal government and private citizens. The Budget includes proposals that will expand and strengthen the tools available to CMS and states to combat fraud, waste, and abuse, including in state Medicaid programs. In total, proposed program integrity investments and authorities in the Budget will yield an estimated \$25.7 billion in scorable and non-scorable savings to Medicare and Medicaid over ten years.

Focusing on Stewardship. To improve the efficiency of the Medicare appeals system and reduce the backlog of appeals awaiting adjudication at the Office of Medicare Hearings and Appeals (OMHA), HHS has developed a comprehensive strategy that involves additional funding, administrative actions, and legislative proposals. The Budget includes resources at all

levels of appeal to increase adjudication capacity and advances new strategies to alleviate the current backlog. The Budget also includes a package of legislative proposals that provide new authority and additional funding to address the backlog.

Conclusion

Members of the Committee, thank you for the opportunity to testify today and for your continued leadership on these important issues. I am grateful to have you as partners as we make the investments critical for today while laying a stronger foundation for tomorrow. I want to conclude by thanking the men and women of our Department, who work tirelessly every day to deliver impact for those we serve—the American people. I welcome your questions.



Sylvia Mathews Burwell

HHS Secretary

HHS Office of the Secretary

Sylvia Mathews Burwell was sworn in as the 22nd Secretary of Health & Human Services (HHS) on June 9, 2014.

A results-driven manager, Secretary Burwell has led large and complex organizations across the public and private sectors.

As the Secretary of HHS, Burwell oversees more than 77,000 employees, in work that touches the lives of Americans at every age, from every background, in every part of our country. She is committed to the mission of ensuring that every American has access to the building blocks of healthy and productive lives.

Secretary Burwell has called for the Department to operate under three guiding tenets: to deliver results on a wide range of complex issues, to strengthen the relationships that drive progress, and to build strong teams with the talent and focus needed to deliver impact for the American people.

Most recently, Burwell served as Director of the Office of Management and Budget (OMB), where she worked closely with Congress to help return to a more orderly budget and appropriations process that brought needed stability to the economy and middle-class families. She led the Administration's efforts to deliver a smarter, more innovative and more accountable government. She oversaw the development of the President's Second-Term Management Agenda, including efforts to expedite high-impact permitting projects, drive efficiencies, and improve customer service. Additionally, she worked to ensure that our regulatory system protects the health and safety of Americans, while promoting economic growth, job creation, and innovation.

Prior to serving in the Administration, Burwell served as President of the Walmart Foundation in Bentonville, Arkansas, where she led efforts to fight hunger in America, empower women around the world, and leverage Walmart's presence in local communities to reach millions of people. During her tenure, the Foundation surpassed \$1 billion in total giving.

Before joining the Foundation in 2012, she was President of the Global Development Program at the Bill & Melinda Gates Foundation in Seattle, Washington, where she spent 10 years working on some of the world's most pressing challenges, from vaccinations to children's health to agricultural development. She also served as the Foundation's first Chief Operating Officer.

During the Clinton Administration, Burwell served as Deputy Director of OMB, Deputy Chief of Staff to the President, Chief of Staff to the Secretary of the Treasury, and Staff Director of the National Economic Council.

Prior to joining the Clinton Administration, Burwell worked for McKinsey & Company. She has served on the boards of the Council on Foreign Relations, MetLife, and the University of Washington Medical Center, among other organizations.

Secretary Burwell received an A.B. from Harvard University and a B.A. from Oxford University, where she was a Rhodes Scholar.

A second-generation Greek-American, Burwell hails from Hinton, West Virginia. She and her husband Stephen live in Washington, D.C. with their two young children.

MANDATORY PROPOSALS IN FY 2017 BUDGET REQUEST

Mr. COLE. Thank you very much, Madam Secretary. And again, it is a pleasure to have you here.

The President's budget is being touted as adhering to spending caps agreed on last year, but it does so by the inclusion of gimmicks which shift funding onto the mandatory side of the budget ledger. For example, as you know and has been mentioned here actually by both sides, NIH discretionary level is reduced by \$1,000,000,000 from fiscal year 2016 levels.

Let me just tell you up front that is not going to happen. We are not going to be cutting \$1,000,000,000 out of the NIH, and frankly, we are unlikely to be able to get mandatory funding of \$1,800,000,000. Again, we have no jurisdiction in that area, but I will make a prediction that we are unlikely to be able to get that.

Having said that, that means—and that would probably apply to the other mandatory areas that you called on as well, although we will look at each one of them individually, obviously. Given that, you know, we are going to have to shuffle money around to maintain programs because we don't have our allocation yet, but the entire discretionary side of the budget, I think, was increased by 0.1 percent under last year's agreement.

So there is not a lot extra there. So we are going to have to make some really tough decisions. It would be very helpful to us if you would tell us what are your top three or four priorities within the budget and that you think are absolutely critical to being funded?

Secretary BURWELL. So as we think about the issue of tough decisions, I think you appropriately reflected, when we look at the second year of the deal, it is a very, very small increase, and with other things that happened naturally that, you know, the question of "Is it an increase at all?" for most of the bills I think is an important one.

And I think that is a reflection of where our discretionary levels are. In this budget, by 2019, we will have one of the lowest levels of our discretionary-to-GDP ratios that we have seen as a nation. And so I think the question about priorities and tough decisions, I think we feel we made those because everything is paid for.

And that is the issue when we talk about the budgeting. In terms of the mechanisms that we use, discretionary or mandatory, I think what we are all focused on is how much we spend and how that affects and impacts the deficit. And the budget overall keeps us on a downward trajectory.

We made decisions that may not be the ones that folks agree with, and we understand and appreciate that, but we do pay for everything, and we do continue on our path of deficit reduction and making sure our debt-to-GDP ratio is on a declining path, as well as our deficit.

So in making the tough choices and the prioritizing, we have done that in the means by which we pay for these things.

FY 2017 BUDGET REQUEST PRIORITIES

Mr. COLE. Well, I am the last person to cross swords with a former OMB Director about the budget, but I don't think we are

on a downward trajectory. Certainly, in gross dollar terms, the deficit is going to be higher this year than it was last year.

And I think this is off our topic, but I think one of the great missed opportunities of the President's second term was real entitlement reform. There was a couple of times he was close. I mean, he put, to be fair to him, change CPI on the table, and he put means testing for Medicare on the table.

But he also put—demanded tax increases, a lot of other things with those. We could have probably passed those things, and I think they would have been a material improvement on where we are now.

But that aside, we are unlikely to be able to do that in the short term and the amount of time that we have left, and what we do have to do and want to achieve is to actually give you a real budget. So I am going to return again, of the budget itself, what are the three or four top things of what you have submitted that you think are absolutely critical to the functioning of health and human services?

Secretary BURWELL. So, as I said, I think we have put together the budget in a way that reflects our priorities. I think we have heard criticisms, and I am sure I am going to hear them today, in terms of the cuts that we have made to other areas, places where we have not fully funded and had to make choices. And I am sure we are going to talk about those, whether that is, you know, the issues of REACH or the issues of BARDA. I am sure that we will talk about those today and have made a number of those choices.

The other thing I would just reflect, as we think about the overall budget picture, is the question of demographics in our country. And we know that healthcare is one of the most fundamental drivers of the costs causing these issues. But I think we also know that the basic demographics in our country with regard to we are going to have more people who are in that Medicare band, and so how we think about a balanced approach.

And that gets to this question of revenues versus cuts because the problem isn't simply a problem of a set number, you know? It is that increase. And I keep my eye on per capita healthcare costs, and in Medicare, we have seen those be very low for six consecutive years.

And so, as we continue to think about it, I think that is an important part of the conversation, which I think you know I welcomed in my OMB job and I welcome here.

Mr. COLE. You did. And you have always been a good person to have that dialogue with. With that, I want to move to my ranking member for whatever questions she cares to put to you.

Thank you.

FLINT, MI WATER CRISIS

Ms. DELAURO. Thank you very much, Mr. Chairman.

I just would like to remind everyone that Labor, HHS has 32 percent of the nondefense discretionary budget. If we had received an allocation that was commensurate with our portion of discretionary spending, we would have received an additional \$5,200,000,000 to what we have had. If that happens this time

with our allocation, yes, in fact, we can accomplish what we want to accomplish in this budget.

And that is our portion of discretionary spending, and we were shortchanged last time. And we should not be shortchanged this time. And with that, Madam Secretary, let me just say that and let me talk about Flint for a second.

Unbelievable tragedy, 8,000 kids. Doctors, everyone tells us lead poisoning is irreversible, OK? But it is the short term, we need to ensure Flint's drinking water is safe. We also need to think about medium term and long term, and I know you are the lead agency here, and I just want to run down a few things to find out where you are overall in addressing this issue.

What is HHS doing to ensure that every child who has been exposed to lead has a case manager to ensure they receive the services they need? You provided \$500,000 to two community health centers. That is a start.

I would like to know how we are going to ensure that Flint has sufficient capacity to treat these kids for years to come. It is the longevity of the Federal response here.

Head Start serves about 1,000 kids in Flint. Another 150 are enrolled in Early Head Start. According to the Administration for Children and Families, more than 1,000 income-eligible children are not enrolled in a Head Start program. Nearly 3,000 income-eligible children are not enrolled in Early Head Start. How do we ensure that these kids, when the two areas that we have been told by doctors and scientists, that where we can make a difference in mitigating this lead poisoning for these children, is in good nutrition and early nutrition and in early childhood education. These are the two areas where we can play a role.

So how do we ensure that they don't fall behind and suffer the effects of lead exposure for the rest of their lives? Let me ask you to answer those questions.

Secretary BURWELL. So as you mentioned, the Department of Health and Human Services has been asked to lead the Federal response in Flint, MI. As we lead that response with our objective of supporting the State and local community in getting to a better place, there are two main goals.

The first is clean and safe water in the short term, in the medium term, and the long term. And then the second is understanding the damage that has occurred and then working to mitigate that in support of the State and local community.

With regard to the specifics of your question, a number of them, two of them, I think, come together—the case management question, as well as the question of the capacity and how things come together for those children who may have damage. And I think probably the most important thing, which we are in the process of doing, we will improve a Medicaid waiver in Michigan. The Governor has asked. I met with the Governor. I was in Flint—was it last week, was in Flint, met with the Governor, had these conversations.

There are two very important elements to the Medicaid waiver. The first is expansion to pregnant women and children in terms of the expansion, which we will do. The second, though, is comprehen-

sive case management, which will be a very important part. And the funding to do that will help us in that space.

With regard to the issues of the programs that you mentioned, a number of those programs had conversations also with the Governor and others about how we make sure that those services are going to reach those children.

Ms. DELAUBRO. Are we examining the opportunity for Head Start for all eligible children?

Secretary BURWELL. That has been a part of the conversation.

Ms. DELAUBRO. We have got, what, about 38 seconds. So we are going to continue this, I think, for a while. So I won't overstep my bounds, Mr. Chairman, but will come back on some other things.

Mr. COLE. I thank the gentlelady greatly for staying within the time limit.

With that, we go to my good friend from Arkansas, Mr. Womack.

ELECTRONIC HEALTH RECORDS

Mr. WOMACK. Thank you, Mr. Chairman.

And my thanks to the Secretary also for her service to our Federal Government and our friendship that dates many years.

Secretary Burwell, Congress enacted the High Tech Act with the intention to encourage providers to adopt electronic health records, and today, over 80 percent have them. However, as the meaningful use program has been developed, its regulations have grown far beyond the intent of Congress and have put layers of new requirements on the backs of our doctors. Not only have these requirements become so onerous that it is darned near impossible to comply, but ultimately, they force providers to spend more time on the computer than with the patient.

It seems to me that there has been more of an emphasis on ensuring compliance by providers in achieving meaningful use than there has been on ensuring our providers can comply and that EHR use is actually meaningful. That is very concerning to me.

I have heard these concerns from Arkansas providers frequently. In fact, as of yesterday, another round of visits yielded the same, and I was encouraged to learn that the CMS Acting Administrator and the National Coordinator of Health IT are using the tools provided by the passage of the Medicare Access and CHIP Reauthorization Act of 2015 to transition the Medicare EHR Incentive Program for physicians towards a reality of where we want to go next.

On the eve of these changes to electronic health record meaningful use, can you help me understand how the changes will shift emphasis from the rigid enforcement to making the program truly meaningful to patients and providers? Will the changes provide flexibility for providers? Will they ensure EHR interoperability? And when can we expect these improvements to be released and implemented?

Secretary BURWELL. So I think, as you have heard, we have taken the comments and feedback that we have received and, even as we were doing rulemaking in the fall, announced changes. Acting Administrator Slavitt, as well as Karen DeSalvo at the Office of the National Coordinator, have talked specifically about that.

In terms of the specific things that we will do, MACRA is giving an opportunity to make changes as we go forward. Some of those,

though, we already have put in place. One is we have put out standards. And historically, we hadn't taken the step to articulate what we believe are the correct standards that people should use because that gets us to interoperability.

The second thing, and you will be seeing more on this as soon as Monday, I will be—I am trying to think which day, but I will be speaking to a gathering of 4,000 technology providers in the private sector that are the people who are providing this software. And we will be talking specifically about steps that we are taking forward—together forward in partnership with those companies.

And so what we are trying to do is in the places where we can lead and we give directions, such as setting standards and an interoperability roadmap, that we take those actions, and where we can work with the private sector and where they need to lead to do that. So it is the combination of the two things, and part of that will also be the implementation of MACRA, which we are pleased to do.

It is aggressive. Everyone, I think, should know what you all passed is aggressive. We are excited about that and think that gives us a tool. At the same time, we need the private sector with us, and we are working with them, and you will hear about that on Monday.

Mr. WOMACK. How soon can we see change on this front? How soon can the wheels of progress turn and actually bring some relief to the essence of my question?

Secretary BURWELL. So this was a meeting I had, actually, with the team on Tuesday in specific terms because, for me, the answer to that question has to be 10 months and 20-some days in terms of real change that providers can feel. And I think what providers and consumers are both going to feel, and this is something that you all will probably also work on, is at a minimum, when we take away data blocking, and two things have happened.

We have been clear that we are going to take action in any way we can against data blocking and that we are articulating it. When the Congress articulated that it would act—and data blocking is where these providers of the technology, they can do it either, it can be omission or commission. They can actually do things that block an ability of consumers to get that data, or they can do things that don't really completely block it but make it harder in terms of not providing.

There are things that are happening in that space that we are going to feel a difference within the year.

Mr. WOMACK. One of the real concerns I have, we have a number of providers that fall into this category that are getting to the age now where they either have to comply or they may choose to just leave the profession. There are a number of providers out there that still have a lot to offer in terms of medicine, but yet are just leaving the enterprise. So is that of concern to you?

Secretary BURWELL. It is, and that is why—yes, it is, which is why we have got to get it to where the value of this outweighs the difficulty in doing it. And I would just ask everyone to watch for that when you all conference on 21st Century Cures, the Senate side will put in provisions that are related to this very issue.

And as it comes back, my expectation, there will be a conference, please watch there because that is a place where legislation may help us.

Mr. WOMACK. Thank you.

Mr. Chairman, I yield back.

Mr. COLE. Thank you.

With that, I move to my good friend, the gentlelady from New York.

GUN VIOLENCE RESEARCH

Mrs. LOWEY. Thank you again, Mr. Chairman.

Thank you, Secretary Burwell.

According to the Brady Campaign, 31 Americans are murdered with guns each day. One hundred fifty-one are treated in an emergency room due to a gun assault. That is not all. The U.S. firearm homicide rate is 20 times higher than the rates of 22 of our peers in wealth and population combined.

So I really think about it and wonder why. For instance, is it possible there are societal trends or other factors unrelated to gun purchases and ownership that may be important to study to reduce gun deaths? The Federal Government and in particular agencies within your department, such as the National Institutes of Health, Centers for Disease Control, are some of the leading public health research institutions in the world.

So I am baffled that rather than arm them with the scientific knowledge to save lives, some on the other side have supported efforts to stifle this research. Now I just want to say I worked with former Representative Dickey, and I remember when that amendment about 20 years ago was put on the bill. And he has already spoken out against it and said we should do the research.

So I would like to ask you, are there public health reasons why the CDC should not be conducting research into injury prevention due to gun violence? If the committee were to fund the President's request of \$10,000,000 to study injury prevention due to firearms, what type of research could be funded?

Secretary BURWELL. We believe that we should do the research, and it is a matter of funding. So for us at the Centers for Disease Control and Prevention, if we had those monies, we would do the kind of research that you described in terms of trying to understand why they occur, and as you said, it can be a range of reasons, societal reasons and other reasons. But we actually don't know because we haven't been able to do the research.

So as we have proposed in our budget, we would like to see that money so that we can start that work.

Mrs. LOWEY. Thank you. And I hope we can make that happen, Mr. Chairman. It would be a good thing for the country.

EBOLA VIRUS RESPONSE

We have made great progress since the Ebola epidemic reached historic proportions in 2014, but we are not yet done combating the Ebola threat, and our public health infrastructure, including researchers, hospitals, physicians on the front line, have not yet completed the mission to eradicate this deadly disease and protect the public. In short, rather than continue to wipe out Ebola, my friends

on the other side seem prepared to declare mission accomplished when cases may still emerge.

What remaining Ebola efforts would be prevented or delayed if funding were to be used for the Zika virus, and in particular, are there medical countermeasures that could be impacted as a result of using Ebola funding for the Zika virus?

Secretary BURWELL. With regard to the countermeasures, yes, there are a number of things. We should be hearing from the WHO. I will be meeting with Margaret Chan tomorrow morning at 7:00 a.m. because we need the results of the ring trial that was done on the Ebola vaccine.

We are also seeing the work on ZMapp, which was one of the issues, and I read this morning there will be another study coming out in terms of some of the types of tools that we can use even in the treatment space, which we haven't historically seen. So we are going to be seeing a number of things that would come online that we will use those monies and ask for BARDA and Bioshield to move forward if we can.

The other thing that I think is extremely important in terms of those monies is the Global Health Security Agenda. Right now, in Nigeria, we have Lassa and measles. But because we are investing those monies in prevention, detection, and response, that is what the Global Health Security money that you gave us to spend over 5 years for countries to put together plans, we are exercising those monies.

Three hundred individuals were at CDC, and I will not go through all of the outbreaks that are occurring or the fact that last year, we had the most cases of Middle East Respiratory Syndrome coronavirus—respiratory, these are the ones that really spread quickly—out of the Middle East, Saudi Arabia, that we have ever had as a nation.

MERS was controlled because Korea had the capability to do it. We supported them. We sent people from CDC. But it happened, and no one even knows about that, which would have been like Zika, if it had grown.

And so those are the things the money is being used for, and we think those are priorities. As you probably know, yesterday we sent up letters. I have done a reprogramming of existing monies from the Prevention Public Health Fund to keep CDC going, and we have sent you all a letter on two transfers.

And so we are doing everything we can to keep our efforts going right now on Zika, but the demand is great. Today, I got my numbers this morning. There are 155 cases in the United States. You have seen the numbers, and you have seen the sexual transmission.

In Puerto Rico, we think those cases—because we depend on a set number, I think the cases are actually higher. So those numbers will continue to rise quickly.

Mrs. LOWEY. Thank you. And thank you, Mr. Chair.

Mr. COLE. Thank you.

The gentleman from Tennessee, Mr. Fleischmann, is recognized.

SPECIAL ENROLLMENT PERIODS

Mr. FLEISCHMANN. Thank you, Mr. Chairman.

Madam Secretary, thank you for being before us today and appreciate your phone calls and all of your hard work and hard efforts. Thank you.

Madam Secretary, I have got some questions. I am concerned that the recent news indicates too much instability in the individual market. Although you are highlighting a 90 percent coverage rate, enrollment expansion in the individual market are far below initial projections.

Consumers who are willing to do their part by paying a full year of premiums are paying higher rates because the exchanges allow people to sign up for just-in-time medical services during what are designated as special enrollment periods.

I am also concerned about the ever-moving and expanding open enrollment period. The original ACA regulations had open enrollment periods that ended in early December. Allowing individuals to continue to enroll after the current policy year can encourage anti-selection and letting purchasers pay for only a partial year of coverage while still receiving a full year of coverage.

My two questions, Madam Secretary, are does the HHS plan to significantly eliminate more SEPs in the near future, and does HHS plan to limit or expand the open enrollment period?

Thank you.

Secretary BURWELL. So with regard to the issue of the special enrollment periods, we have announced that we have gotten rid of a number of those special enrollment periods, as your question reflects. So, yes, we have gotten rid of them.

In addition to that, we have put out clearer guidelines with regard to making sure people know so that we narrow that frame in terms of people doing it. And yesterday, we actually put out information that you will have to provide documentation, which is one of the issues that the issuers have talked to us about, in order to promote a more stable market. So we are taking those steps in terms of those that were in your suggestion.

With regard to the broader question of numbers, I do think it is important that when we think about what the objective here was, the objective was access to insurance and then moving to coverage when we think about the Affordable Care Act. And with regard to the CBO numbers, in the original CBO numbers, as we look at the tracking of the number of the uninsured—the reduction is slightly higher than CBO projected.

What we know is that not as many people have moved from employer-based care into the marketplace, and we actually think that is fine in terms of the marketplace not growing by taking employer-based care in. And so we think that is an acceptable thing.

Having said that, we want to make sure we are listening, and that is why the issues you raised are a number of issues the issuers have raised with us, and we have taken action on those as they go into this period to determine their participation in the next open enrollment.

COMMUNITY HEALTH CENTERS

Mr. FLEISCHMANN. Thank you. I would like to shift to community health centers, if I may?

Madam Secretary, I would like to discuss the funding cliff that community health centers face. As you know, mandatory funding is due to end after fiscal year 2017. It is my understanding that a large portion of this funding supports basic, ongoing health center operations. Can you share with us what the alternatives are if the authorizers do not act on your request for an additional 2 years of mandatory funding?

I know these centers have been a source of medical care for the uninsured. Can you explain to us the implementation of the Affordable Care Act and how it is affecting the health center financial model, given that nearly everyone ought to have some form of insurance coverage by now that the health centers can bill.

Secretary BURWELL. So we are hopeful that we can get the extension because it serves so many people, as you articulated, in terms of the millions and millions of folks. I think it is 1 in 14 Americans are served by a community health center in the country. And so the amount of services those are providing is extremely important.

With regard to the issue of the finances, when I go and meet with federally qualified health centers, their finances are improving. They are improving in two cases. One, they are improving because people have coverage now, and they use that to expand their services. And whether that is in the issue of dental or other services that they can provide, behavioral health and that sort of thing. So they are using that money.

And in Medicaid expansion States, that is the other place where they are getting those benefits. These health centers are going to be the backbone of everything from some of our behavioral health work to increasing our medication-assisted treatment programs with opioids, and in our budget right now, we have proposed that we can start using telemedicine. So they can be the centers, and this is important for rural America in terms of issues in rural settings where telemedicine can be a real opportunity for both quality improvements and cost reduction.

So those are some of the reasons we think it is extremely important to continue.

Mr. FLEISCHMANN. Thank you, Madam Secretary.

Mr. Chairman, I will yield back.

Mr. COLE. I thank the gentleman.

My good friend from Philadelphia is recognized next, Mr. Fattah.

BRAIN INITIATIVE

Mr. FATTAH. Thank you.

And Madam Secretary, it is good to see you this morning. Your focus on the Affordable Care Act and its implementation has led to an historic level of participation. And particularly in Philadelphia, and you came personally to my district and helped launch an enrollment effort.

And I think we lead the country. We might still be in a competition with Miami. I am not sure. But I will just claim the victory and credit your great leadership with it.

There is so much that I want to ask you about. We only have a few minutes. Let me start with our work on the neuroscience front, on the BRAIN Initiative.

NIH's participation and leadership in it is obviously critical. I want to thank the chairman. Working with us last year, we were able to fully fund these initiatives. And as the administration comes to the end of this period, it is going to be important that this work not be interrupted.

We have some 50 million Americans suffering from a brain-related illness. The efforts of NIH, along with the National Science Foundation and DARPA and a host of a dozen other Federal agencies, the VA and so on, this work is critically important.

So be interested in your thought about how to make sure that we can structure the baton pass correctly and that this work can go forward.

Secretary BURWELL. So I think one of the most important things is that it is housed at NIH, which I think under any administration will continue. And I think the BRAIN work and the demand around the BRAIN work, whether that is concussions, Alzheimer's, is great. And so I think we are hopeful that this will continue to be a priority.

I think the other way we get the continuity is already happening. Thank you all for the support that you provided last year. We have already issued 125 awards. So those scientists are doing their work to provide the input, and I think, as you know, it is not one effort. It is about research in a number of different areas and places because the brain, right now, our knowledge is pretty limited, and there are so many conditions and diseases that are related.

And so those 125 awards are out, and I think that is the other place and way that we will be able to continue this effort and get results.

Mr. FATTAH. Thank you.

COMMUNITY HEALTH CENTERS

And the—in your testimony, you talked about the community health centers, and my colleague has already asked you because we are going to arrive at an important challenging moment for the community health centers. Now this is my priority and a number of our other colleagues, I know Barbara Lee and others. In the Affordable Care Act, we provided a very significant ramp-up for federally qualified community health centers. The last thing we want to do is have one out of every nine Americans being able to use those centers now and then get to a point in 2017 to have a problem.

So we want to work with the authorizers and the administration and get what we think is a modest request. Your request is for a 2-year?

Secretary BURWELL. Yes.

Mr. FATTAH. Right. To make sure that that happens. So this is very, very important.

PRECISION MEDICINE INITIATIVE

And then you have a very significant increase in the precision healthcare portion of the budget. We provided money last year, and this is an area that is vitally important and builds on the work of the Human Genome Project and a host of things.

So if you could talk a little bit about how you see the progress from last year's funding. I know you just started to move that money, but if you could talk to us a little bit about that.

Secretary BURWELL. So two places in terms of specifics where the Precision Medicine Initiative, and thank you all for the support for the funding, in terms of where the progress is being made.

The first is, I would say, in the cancer area. That is the place that is the most ripe and where we are moving the dollars through the National Cancer Institute to continue to do research in the genomic space. And this is about the genomics of the tumor. And so that we can actually instead of saying, "You have kidney cancer," we look at your tumor.

And I met the gentleman at NIH who his family had had a number of members die. He lost one kidney. He had over 30 tumors removed, and they kept growing back. But once we analyzed his tumor genetically and treated it in that form, versus treating kidney cancer, we were able to make progress. And so those are the kinds and types of examples.

The other place where that money is going to come to fruition is, and I think the President is doing an event either now or this afternoon on Precision Medicine, we will be working with the private sector on some of their engagement. But I think the big thing is getting the cohort, the group of people who will come in and be a part of creating a broad group of people where research can be done.

And so we have put in place some of the privacy recommendations, some of the security recommendations, so that we build the right platform as people want to and can come in.

Mr. FATTAH. Thank you.

Thank you, Mr. Chairman.

DEFICIT REDUCTION

Mr. COLE. Thank you. And we next move to Dr. Harris.

Mr. HARRIS. Thank you very much.

And thank you, Madam Secretary, for being here today.

First, I just got to clear up a question I have got because somehow you talk about the budget being—showing deficit reduction. And I have got to tell you, I—because I just pulled up the President's budget, and am I correct that the President's budget projects a deficit in 2026 of \$793,000,000,000?

Secretary BURWELL. With regard to the specifics of that number, I will trust if you have the budget in front of you because—

Mr. HARRIS. OK. It says \$793,000,000,000, Madam Secretary. And the CBO estimates this year's is \$541,000,000,000. And I got to tell you, this is why people don't trust Washington.

This is why we look at the presidential race, and we wonder. We scratch our heads like, "Why is it going the way it is?" Because only in Washington, honestly, could a Secretary come before a committee and say that raising the deficit from \$541,000,000,000 this year to \$793,000,000,000 in 2026 is deficit reduction.

This is the problem, and this is not a question. This is comment. This is the problem with Washington.

That being said, we got a problem because we project and the President's budget actually projects a debt of \$21,300,000,000,000 in 2026, 21.3 the publicly held debt. This is a real problem.

So we got to look at how we fund things, and first question I have is the Zika funding request. Is that above the caps?

Secretary BURWELL. It is an emergency supplemental, yes.

Mr. HARRIS. So it is above the caps.

Secretary BURWELL. Correct.

Mr. HARRIS. So, actually, we are sitting on a \$541,000,000,000 deficit, and we are—the administration comes in and says this is emergency funding. Now I will tell you, when I was in the Navy, we had a saying that the Navy went from crisis to crisis unimpeded by plans.

Within one year, we have had requests, I think the last request for Ebola, someone can correct me, \$6,000,000,000? I mean, it is just billions and billions of dollars. That was an emergency request. Now we have got an emergency request.

Is there a plan somewhere? And then I go, oh, my gosh. There is a plan. It is called BARDA. It is actually called—we actually have a plan to fund projected problems into the future. And what did the administration do? They come and say, yeah, we got a plan, and we need a certain amount of money, and we are only going to spend half of that.

We are going to ask you for emergency funding, but actually one of the plans we have so that we are not going crisis to crisis so that, for instance, when there is anthrax outbreak, we actually have the medications to treat it. When there are the—or I can go down the whole list of BARDA. So that actually we don't end up with a crisis, the administration chooses to underfund that program.

Where is the plan?

Secretary BURWELL. So—

Mr. HARRIS. Because Zika and Ebola are actually, you know, although they are different viruses, they are actually the idea that we should have a plan and say we have to develop a method to rapidly react without emergency funding.

So, for instance, could you describe the plan to rapidly develop vaccines and get them approved and how much we are spending on that plan?

Secretary BURWELL. So, Dr. Harris, I think that the fundamental cost in both Ebola and in Zika actually has to do with public health for the American people and not the actual cost, the amounts of money needed in terms of vaccine development and deployment, if you have them. But with regard to the cost for both Ebola and Zika, right now what we need to do is make sure that we are getting the right information and doing the diagnostic testing.

Right now, the Governor of Florida, I read this morning in the newspaper, he has asked me for more tests. Right now, with regard to that is a CDC function. The questions of Ebola and Zika, right now we know in this country, 14 women are pregnant who have had the virus. We don't want that to continue. We don't want more.

We don't know. I can't tell you how long Zika lasts in semen. Neither can Dr. Frieden, neither can Dr. Fauci.

Mr. HARRIS. Madam Secretary, I absolutely agree, and I have a list of questions.

Secretary BURWELL. Those are the funds—

Mr. HARRIS. So I am just going to keep on going.

Secretary BURWELL. Those are the funds that I think you are asking for.

Mr. HARRIS. Is the public health—you have a public health prevention fund in your department, don't you, started by the ACA?

Secretary BURWELL. We do.

Mr. HARRIS. How much of that money is appropriated to Zika for next year?

Secretary BURWELL. In terms of that fund, as I mentioned earlier, we have asked—in terms of the prevention fund?

Mr. HARRIS. That is right. How much in your budget of that prevention fund is going toward it because that—

Secretary BURWELL. There is no prevention fund. I just sent up a letter that actually we are using some of the monies for those in terms of other carryover balances. Now which prevention fund you are talking about—

Mr. HARRIS. Now how, Madam Secretary, the public health—

Secretary BURWELL [continuing]. Because there is a Prevention and Public Health Fund that you all told us—

Mr. HARRIS [continuing]. Prevention fund. The Public Health and Prevention Fund that is funded—that was established by the ACA for the purpose including vaccines. So we are told, well, we have to develop a Zika vaccine. Are we using currently available funds before we ask for emergency funds?

Secretary BURWELL. Those fundings have been allocated by Congress. It happened 2 years ago. In the first year I was in the administration, the administration had choice. After that, the Congress, in the last 2, maybe 3 years—I will ask the chairman. But in the last 2 at least, you all have given us very specific allocations for those monies.

Mr. HARRIS. And have you asked for the Zika funding to come from that allocation instead of an emergency allocation that is outside the budget caps?

Secretary BURWELL. Dr. Harris, we believe in terms of the trade-offs that we need to make in an emergency situation, where babies are being born with microcephaly that we believe it is an emergency.

Mr. HARRIS. I yield back.

Mr. COLE. Thank you very much.

We will next go to my good friend from California, the gentlelady, Ms. Lee.

Ms. LEE. Thank you very much. Good to see you, Madam Secretary.

Secretary BURWELL. Thank you.

DIVERSE WORKFORCE

Ms. LEE. And I just want to remind this committee, you know, I think our allocation right now continues to be, what is it, 10 percent below pre-sequestration levels? And so we need to really recognize that and try to understand the fact that this allocation at this level continues to really hamper our ability to address our Nation's

current and emerging health needs. It is really too bad, and hopefully, we can get a better allocation this year.

A couple of things I would like to ask you about. Of course, you know the Health Careers Opportunity Program, I have been calling for years now to make sure that we fund it. So I am really glad to see that there are resources in this budget for that.

But I want to ask you about why you are eliminating the area health education centers, which are really critical for minority and low-income families, according to—in terms of ensuring medical school training and healthcare training. There is a statistic I want to raise at this committee during this hearing that the Association of American Medical Colleges put forward.

There were fewer African-American males enrolled in medical school now than in 1978, and so by eliminating this program, I want to see how you are going to really address the emerging needs of diversity in the health workforce and halt this disturbing trend.

Secondly, as it relates to the Asian Pacific American Caucus, I serve as the co-chair of CAPAC, and we have many, many issues we have been addressing, and thank you for your assistance and leadership on this. But the Racial and Ethnic Approaches to Community Health, that is the REACH program, it has historically provided direct support to the AAPI community.

Of course, with higher rates of health morbidity and mortality, this initiative is so important. REACH has documented success in engaging Asian Pacific Americans in healthcare, healthcare prevention, but yet this budget proposes to cut \$20,000,000 out of REACH. And so this is a very specific, unique program that really helps with the healthcare needs of the AAPI community.

So I wanted to ask you why the cut? And do we see that somewhere else in the budget at this point and just emphasize the importance of that to the AAPI community.

Secretary BURWELL. So the issues of diversity, both in two forms, in terms of making sure we have healthcare providers that are diverse as one of our priorities, as well as the issue of making sure we are serving communities and communities that sometime have disproportionate needs.

With regard to the overall educational issue, I think you know and as you stated in your beginning comment, we are in a state of a limited budget. And with regard to the specifics of the program, what we have chosen to do to try and work on those numbers that you said, the 1978 to now—

Ms. LEE. Really big numbers, yeah.

Secretary BURWELL. What we are hopeful is, is by focusing on the programs that actually are closer to that point of getting the people in. And so the funding that you see in terms of our Public Health Service Commissioned Corps, and that is not the Commissioned Corps, but the Public Health Service Commissioned Corps in terms of that has over one-third minorities. And by investing there, we are getting those folks in at that point at which they are so close, and they are at the point at which they are making decisions.

And so trying to focus on the point where we would have the most leverage with limited resources.

Ms. LEE. Is that why you eliminated the area health education centers?

Secretary BURWELL. Yes. Because in terms of trying to figure out in a world of limited resources where our dollars can have the most impact, those were the choices that we made.

With regard to the broader overall issue, our investments in community health centers has been articulated as well as they are very important to serving and providing monies for diverse communities. In addition, the Affordable Care Act and the issue of getting people insurance is one of the most important things that we believe and we are deeply focused on in terms of changing the dynamic of the disproportionate and the inequities in minority populations.

We know that getting people coverage is not enough, and we have to move that coverage to care, and in the last year, you have seen efforts in that place through CMS, as well as through the community health center.

Ms. LEE. OK. But the cut, the \$20,000,000 cut in terms of the REACH program, because it has been so successful in addressing the Asian Pacific American community, why the cut and where do we see that focus again in another line item?

Secretary BURWELL. I think what we want to do with the proposal that we have in front of us is to be able to do some of that evaluation to understand how we can make that program as strong as we possibly can. And when we do that, think about then where and how are the places that we can expand it.

Ms. LEE. OK, not expand it, but why would you cut it? I am just trying to understand the cut.

Secretary BURWELL. In a world of limited resources, as I said—

Ms. LEE. That is limited resources. So once again—so ethnic minorities, again, are getting cut in this budget like everybody—

Secretary BURWELL. Across the board, I think—well, like everyone. Because I think what we have tried to do in terms of care for these populations, there are a number of other areas where we have tried to make sure that we have either maintained or increased because we know the disparities are great.

Ms. LEE. OK. And then viral hepatitis, I have time? Any more time?

Mr. COLE. I would ask you to look at the time.

Ms. LEE. OK. I will get it next time around.

Mr. COLE. Thank you. Just with the indulgence of the members of the committee, I will say for the record, I know 12 cardinals and 12 ranking members that are convinced that their allocations are too low, and I can say with certainty that the cardinals and ranking members on Interior, Defense, and this committee are absolutely correct.

[Laughter.]

Mr. COLE. With that, I am going to move to my good friend and, sadly, retiring Member. So it is also his last appearance here, and Mr. Rigell, you have made great contribution to this committee. You will be greatly missed in Congress.

ALZHEIMER'S DISEASE

Mr. RIGELL. Thank you. Even though I am way down here on the end.

Listen, and what a privilege it is to serve on your committee and with the ranking member and just the individuals that we get to interact with. And I join the others in thanking you for your service. I want to talk about something that is affecting so many American families, Alzheimer's.

I have a kind of a little window into it just because of the fact that my parents are still living. They are doing so well. They are 93 and 88, and we Facetime every Sunday morning at 8:00 a.m. And sometimes the conversation pivots over to their friends, and they start describing—they start naming names, and well, they are the names of my childhood friends, their parents, of course. Their parents.

So I know them, and they just—they have to talk about how painful it is because they don't know where they are and all those other symptoms of that horrific disease. And I know that we increased research by 60 percent, and I am so supportive of that.

But as I think about how we have extended the length of life and not the quality of life, and I think about how organizations from time to time miss real critical moments, like the housing crisis of 2008–09. You know, we missed that. We didn't really see that coming, at least most people didn't.

And it was like the Challenger disaster, if you look back at it from a managerial standpoint, they could see where they went wrong. And I feel like we are in that same boat with respect to Alzheimer's.

I am a fiscal conservative, and yet embraced in all of this, and I also brought my heart to Washington, my mind, and my calculator and everything else. But I really would submit to the committee that I think we are far lower than we need to be. And I say this as a nonmedical professional.

But, so I have two questions for you. The first one is how have we managed that 60 percent increase? And please don't spend too much time on that because our time runs out so quickly. But I want to ask a hypothetical question. I think you will appreciate the question.

But if you could invest in that particular area not to the detriment of the other areas—I am giving you a hypothetical. If you could just—because at some point, the water starts to flow out of the glass. I mean, there is just more money than we can really apply to the research.

But what is that theoretical limit of what you would want to apply to research to Alzheimer's? Because I think this is the number-one challenge facing our country for a host of reasons—quality of life and, indeed—and indeed, fiscal, the fiscal aspect of it. So could you walk us through that, please?

Secretary BURWELL. So with regard to that answer, I actually would want to consult with NIH, and here is why. And it actually gets to a part of what Dr. Harris raised. In terms of our BARDA monies, in terms of managing the taxpayers' money well, those monies that we took down were Bioshield monies, and it is because

the science is not ready and our contracting ability in terms of negotiating, we won't negotiate more. And so we have carryover balances.

And so how I would answer that question actually is related to where the science is because I wouldn't just want to put out a number. I actually would want to know that we believed that we could spend the money well.

And so I am happy to talk to our colleagues at NIH and get back to you with that because I actually think that is important that when we care deeply about things and are passionate about them, I still think we have to use some methods of standards of with regard to using the money.

Mr. RIGELL. Oh, I absolutely support that.

Secretary BURWELL. And I am sure you agree with that. Yes.

Mr. RIGELL. As a business person who—and whether in office or out of office, I am going to continue to advocate for this because I think it is the right thing for our country, and I think I will do so as a fiscal conservative.

It may surprise the chairman, but I was actually called out just a little bit in the Financial Services Committee by one of our colleagues on the other side, accusing—well, saying that I was like raising my voice, I believe, or something because it was an Office of Management and Budget Director there, and I was actually pressing this whole point about our fiscal situation.

And I share the views that have been expressed here, particularly on our side here, that I don't believe the administration has fully grasped the threat of our fiscal—the risk that we have, and he is not fighting for it. I didn't see him fight for it in the State of the Union, for example.

I walked out just really stunned at the lack of attention to this matter, and I acknowledge easily and quickly that both sides have contributed to it. But I am $\frac{1}{435}$ th of $\frac{1}{2}$ of $\frac{1}{2}$ of this part of the Government that actually works on all this. He is one-half. And I am just going to take this opportunity to share with you, as I did with Director Donovan, that I don't think we are grasping the severity of our fiscal situation.

I want my President in his remaining term of office here—I am not expecting much, actually—but to really bring a clarion call to this and to do what is needed to set our country on a better fiscal path for a host of reasons.

And I want to respect the time, and Madam Secretary, I appreciate your service, and I share the respect that all of us here have for you.

Thank you.

Secretary BURWELL. Thank you. Thank you.

Mr. COLE. Thank you.

RACIAL AND ETHNIC HEALTH DISPARITIES

We will next go to my other friend, the gentlelady from California, Ms. Roybal-Allard.

Ms. ROYBAL-ALLARD. Thank you, Mr. Chairman.

And welcome, Madam Secretary.

Let me begin, first of all, by expressing my concern also, as Ms. Lee did, with the \$21,000,000 cut to the REACH program. And I

can't help but question that even though there have been 150 journal articles documenting the achievements of REACH in reducing health disparities, that there is a need for another study. So I just want to put that on for the record.

ADULT IMMUNIZATION

But I have another question regarding adult immunization. As you know, this country is falling woefully behind in our progress toward reaching the Healthy People 2020 goals for adult immunization. And the recently released 2014 National Health Information Survey data confirms very little change in adult immunization rates over the last 4 years, with fewer than 45 percent of adults receiving recommended influenza vaccines and barely 20 percent of adults age 18 to 64 being immunized against pneumonia.

Especially concerning is the fact that immunization coverage among minority populations is even lower. The 2014 data revealed that racial and ethnic disparities persisted for all seven recommended adult vaccines and worsened for both herpes zoster and TDaP.

For these reasons, I was pleased to see that your National Vaccine Program Office recently finalized the National Adult Immunization Plan—

Secretary BURWELL. Yes.

Ms. ROYBAL-ALLARD [continuing]. With four goals centered on improving infrastructure, access, and demand for immunizations, as well as fostering innovation in vaccine development. Could you please describe the short- and long-term steps that your department will take to move the NAIP implementation forward? Specifically, how does the plan address immunization disparities in minority communities, and how will HHS measure progress in bringing adult immunization rates closer to the Healthy People 2020 goals over the next 4 years?

Secretary BURWELL. So I think those four steps that you outlined, especially the access, the infrastructure, and demand, and in terms of when one is thinking about all three of those steps, making sure that we are going to the population that is most underserved in those spaces in terms of the minority populations. And that will guide our communication strategy, as well as how we reach people.

And I think you know some of the tools that we have used in the marketplace, in terms of understanding how to reach consumers where they are, are tools that we will transfer and are learning from throughout the entire department to make sure we are communicating. Because one of the things that we have found is often our communications don't reach people. And often they are not done by people who are trusted.

And so these are two very important lessons that I think from the marketplace that we are going to try and apply. It is why this year, in terms of the places I went for open enrollment, I went to barber shops. I went to beauty shops. We went to churches. Those are the places where people get the information that they trust and use.

And so I think we need to shift some of our approaches to how we do this. Welcome your thoughts specifically on how we can

reach the community and the ways that we are reaching them that you think are working and the ways that we have tried that aren't, so that we can quickly—because I think that consumer feedback, which I hope you are hearing, can help us get to a place where we can be much more effective because it is the larger part of the population with regard to these adult vaccinations that people don't do.

The other thing that I would ask for your help and assistance, in Medicare, one of the things the Affordable Care Act did was it created, you know, preventive services for free. These are included. We have seen some increase in uptake, but not enough.

And so this idea of our targeting needs to be across all age groups and especially adults in that band. Because some of these adult vaccines are especially important as you get older.

MULTI-DRUG RESISTANT TUBERCULOSIS

Ms. ROYBAL-ALLARD. Before he went into politics, my father was a public health educator, responsible for educating the Latino communities in California about the spread and prevention of TB. And because of that experience, I grew up with a healthy respect for the dangers of this disease and have been closely following the case of the 35-year-old man in Los Angeles who has been battling extremely drug-resistant TB for 3 years.

And I was pleased to see the December 2015 White House release of the National Action Plan for Combating Multi-Drug Resistant Tuberculosis, and I want to commend you for this, a thoughtful and very comprehensive 5-year plan to develop new tools for diagnosis and treatment of the new research investments for an effective TB vaccine.

But I am skeptical that the plan will be successful in reducing MDR-TB infection in the United States and abroad without any designated funding for its implementation in your fiscal year 2017 budget proposal. Why was there no funding request for the National Action Plan—

Mr. COLE. I would ask the gentlelady wrap her question up and a quick response, please.

Ms. ROYBAL-ALLARD. Can you provide information on the implementation and the cost?

Secretary BURWELL. Yes, we will provide information on that, as well as the combating antibiotic resistance funding, too, which will be a part of it as well.

[The information follows:]

MULTI-DRUG RESISTANT TUBERCULOSIS

The FY 2017 Budget continues activities within CDC and NIH to advance the goals of the National Action Plan for Combating Multidrug-Resistant Tuberculosis (MDRTB). The Plan is intended to promote greater investment and coordination of U.S. Government resources to reduce the domestic and global risk of MDR-TB and to encourage other bilateral and multilateral donors, the private sector, and affected countries to invest additional resources in these important actions.

CDC's Division of TB Elimination will lead activities for achieving the goals of the Domestic section (Goal 1):

- a. Lay groundwork to upgrade TB surveillance, nationwide, to ensure complete and accurate detection of drug-resistant TB
- b. Explore ways to strengthen state and local capacity to prevent transmission of drug-resistant TB and create surge capacity for drug-resistant TB contact investigations
- c. Explore ways to ensure that patients with drug-resistant TB receive treatment until cured; potential options include creation of a small national TB stockpile of drugs, providing treatment options for those individuals with no medical home, and strengthening management of transnational cases

In addition, CDC will carry out activities in support of the Plan's research goals (Goal 3):

- d. Evaluate treatment regimens to treat drug-resistant TB
- e. Build evidence base for developing strategies to assure completion of therapy
- f. Study correlates of progression from TB infection to active disease
- g. Assess shorter MDR-TB regimens using existing TB drugs

Additionally, the National Institute of Allergy and Infectious Diseases (NIAID), the lead NIH Institute for research on tuberculosis (TB), is playing a critical role in the President's *National Action Plan for Combating Multidrug-resistant Tuberculosis* (MDR-TB). The Federal Government objectives summarized in the *National Action Plan's* Goal 3, Accelerate Basic and Applied Research and Development to Combat MDR-TB, are a focused subset of NIH's ongoing TB research programs that address the critical issue of MDR-TB. NIH will continue to support the full breadth of its existing TB research and development programs. In addition, recognizing the value of domestic and international research and development collaborations, NIH will work to facilitate and enhance existing Federal Government-supported research, as well as research of its domestic and international partners, to combat the emergence and spread of drug-resistant TB.

For example, a longstanding collaboration between NIAID and South Korean scientists focuses on human clinical trials of TB, particularly MDR-TB and extensively drug-resistant TB (XDR-TB). The researchers have shown that linezolid, a drug approved for treatment of other bacterial infections, produced stable long-term cures of patients with XDR-TB. This collaboration includes work designing and evaluating rapid diagnostics for drug resistance, surrogate immunologic markers for determining effective response to therapy, and MDR- and XDR-TB epidemiology.

In summary, NIAID is leveraging current and past investments in biomedical basic, translational, and clinical research for infectious diseases to inform critical scientific areas in TB research and to facilitate development of new drugs, vaccines and diagnostics to help prevent TB and the emergence of MDR- and XDR-TB. NIAID research has contributed to more than half of the current clinical pipeline of TB vaccine candidates, one third of the clinical pipeline of TB drugs and regimens, and many of the diagnostic candidates currently under evaluation. NIAID's TB research programs are built on the principle of collaboration and coordination with relevant stakeholders, strategies, and global funders of biomedical research and are positioned to complement and supplement global research and development.

The White House National Action Plan to Combat Multidrug-Resistant Tuberculosis was developed in response to the recommendations outlined in the National Action Plan for Combating Antibiotic Resistant Bacteria (CARB). It was drafted by an interagency TB Working Group with representation from the United States Agency for International Development (USAID); the National Institutes of Health (NIH); the Centers for Disease Control and Prevention (CDC); the Departments of State, Defense, Veterans Affairs, Homeland Security, and Health and Human Services (HHS); the Office of Science and Technology Policy (OSTP); the Office of Management and Budget; and the National Security Council, and builds on existing mandates of these U.S. Government departments and agencies to advance efforts such as those identified in the WHO's End TB Strategy and the U.S. Government's Global TB Strategy 2015–2019.

60B

Ms. ROYBAL-ALLARD. OK. Thank you.

Mr. COLE. Thank you very much.

I now recognize my good friend, the gentlelady from Alabama, Mrs. Roby.

UNACCOMPANIED CHILDREN

Mrs. ROBY. Thank you, Mr. Chairman.

And thank you, Madam Secretary, and I am sorry that we were unable to connect—

Secretary BURWELL. I apologize.

Mrs. ROBY [continuing]. Prior to today, the chief of the U.S. Border Patrol testified before the Senate that border agents are seeing a dramatic surge in the number of unaccompanied minor illegal immigrants arriving at our southern border. In fact, the border agents have apprehended over 20,000 children from October 2015 to January 2016. That is double the number from the same period last year.

And let me just be clear to my colleagues here today and to the people that I represent, I feel nothing but compassion towards these children, and I think the most compassionate thing that we can do is return these children to their families in their country of origin.

Unfortunately, that is just not happening. Only 4 percent of these children, according to a statement made by my colleague Senator Jeff Sessions, are actually returned to their families in Central America. And as the mother of an 11-year-old girl and hearing the stories about what is happening to these children in this treacherous journey to the United States is horrifying, quite frankly. It is the worst of human trafficking.

And so I don't feel as though there is discouragement coming from the Obama administration. I don't feel like we are sending a very clear message, and I have a real concern about the fact that there is consideration, continued consideration, to house these children on active military bases.

We received a letter between Christmas and New Year's—a week where most people aren't paying attention, but we were—that in fact, Maxwell-Gunter Air Force Base in Montgomery, Alabama, was under consideration to house these children. I met with your Office of Refugee Resettlement recently. We went over all the criteria about why and how this should be done with the military liaison that was there as well.

And I am deeply concerned that any of our military bases remain on the list to house these children. I can share with you, I have a map that shows the buildings where these children are going to potentially be housed at Gunter. And for those who don't know, what happens is the space on these military installations where these children are to be housed is fenced off, and an outside contractor then comes in, most of the time armed, onto a military base. And these children are fenced in an area, a small area, mind you, right next to a neighborhood.

And this is on a military base, Gunter Annex, where everything they do is at top secret clearance. This is a lot of cyber warfare going on. These buildings are just adjacent to the very buildings

where our active military personnel are doing very important missions on behalf of the United States military.

So I share all of this with you. I know we might do a second round, I hope. In the last remaining 1:45, I would like for you to first engage on this, and maybe we can follow up in the next round.

But I just want you to know that I have a very strong opposition. We need to get these children home, and in the meantime, we certainly don't need to have them housed at a military base.

Secretary BURWELL. So I think you know our job is to—once the child is in the United States, make sure that they have appropriate care and are placed in an appropriate and safe setting. And that is the role of HHS.

With regard to the discouragement issue that you raised, which I think is an important one, what we have seen is you are right about the numbers. Of that 20,000, we received 17,000, the 20,000 that they saw, 3,000 never came to us, which mostly usually means they go back immediately through DHS.

But those that came to us, we now have seen a drop-off in January, which is a good thing. But we don't know if that will stay. And so my job is to make sure we have enough facilities that the children don't back up at the border, as we had in that one situation. And this gets to the issue of do we have a plan? Yes, we have a plan.

But in order to have a plan, we have to have an ability to open facilities as quickly as we need them because it is a balance of the taxpayers' money with regard to maintaining empty beds versus when you can bring beds on line.

We appreciate your engagement in helping us review the bases. The bases are an important part of this because the process—and we are looking at other private sites across the country. But as you said, finding sites that can meet the conditions that will work for the city, the community, and the children, both the children's safety, the community's safety, we weight all of those considerations.

Mrs. ROBY. But would you agree with me—and we will continue discussing this. But would you agree with me that a military base is the last place that we want to house these children?

Secretary BURWELL. The issue with the military bases is that they actually have housing and facilities that are needed. When I go and get GSA buildings, the millions and millions of dollars that it will take me to refit, you know, most of the GSA buildings that I would go and try and get in terms of accessing. The other issue, to be honest, is when I access a nongovernment facility, it has to do a process in every State for approval.

Mrs. ROBY. Sorry.

Mr. COLE. I know we got you with a question right at the end. I would just ask——

Mrs. ROBY. I am sorry.

Mr. COLE. That is quite all right. I understand the passion around these issues.

We have had the good fortune to be joined by who we affectionately call "the big chair," and so I am going to move directly to him for whatever statement he cares to make and whatever questions he would care to ask.

Mr. Chairman.

Chairman ROGERS. The big what?

Mr. COLE. The big chair. [Laughter.]

Chairman ROGERS. Well, thank you, Mr. Chairman.

Madam Secretary, it is good to see you. Welcome to the Subcommittee.

Secretary BURWELL. Nice to see you.

OPENING STATEMENT

Chairman ROGERS. I apologize for being late, but we have got 21 hearings this week across our 12 subcommittees, and I had to attend the one across the hall with the Secretary of Defense for a period of time. But I wanted to be here to hear your testimony and be able to chat with you.

As you know, the Congress and the administration set discretionary budget caps for fiscal 2016 and 2017 in the Bipartisan Budget Act, and I am proud to say that the 2016 omnibus stayed within that agreed-upon cap. The budget proposal put forth by the administration for HHS is also touted as adhering to those spending caps, but it is really just an illusion, to be frank with you.

This year, HHS requested \$75,680,000,000. But that number does not include an estimated \$3,800,000,000 that you proposed in mandatory funds to support what are traditionally discretionary programs.

While I very much enjoy our collaboration over time in the immediate past on a host of issues, I am disappointed that the important goals that we share for your department are undermined, frankly, by what I consider a partisan nature of that request. We both know that these figures and budget gimmicks are unrealistic, and frankly, it makes the already very difficult job that we have even more challenging.

We all know that the mandatory side of the budget, and that is three-fourths of Federal spending is mandatory entitlements, growing out of control. We only appropriate a little less than a third of all Federal spending, and we have cut that. We have cut that for the last 5 years back by almost \$200,000,000,000. We have cut discretionary, but mandatory just grows willy-nilly.

And so you are proposing switching some money over to mandatory and outside the jurisdiction of this committee to oversee. That is why it is a difficult thing for us to have to contend with.

There are two areas in particular that see astronomical growth in mandatory spending under your request. First, NIH. National Institutes of Health play an important role in groundbreaking medical research. NIH projects often result in lifesaving medical treatments that impact people all over the world.

This committee understands the importance of NIH. We are all personally committed to NIH and demonstrated that support through an increase of \$2,000,000,000 over fiscal 2015 that we put in the omnibus, thanks to the great work of your chairman, Chairman Cole. It was a bipartisan achievement.

And for the administration to propose its well-publicized \$1,000,000,000 Cancer Moonshot through mandatory spending outside the terms of the BBA, outside the scope of this committee's jurisdiction, it is simply disingenuous. We are all committed to cancer research, all forms of medical research, but we still are gov-

erned by the laws of nature. We have got to make tough choices about how and where to spend taxpayer dollars, and when you thrust this money into mandatory, it puts extra burdens on us to try to find money on discretionary to fund the things that you are displacing.

The same can be said for the \$1,000,000,000 proposal to address our Nation's raging opioid epidemic. Madam Secretary, I sincerely appreciate your efforts to keep the national spotlight on prescription drug and heroin abuse, and you and I have talked about this time and again, month after month, year after year. And you are a soldier in that cause.

I know your roots in neighboring West Virginia. My district and your area are next-door neighbors, and the battle has been waged there for a decade or longer. It has been a source of personal motivation that you have dedicated to that cause, and you have taken, indeed, strong, decisive action to eradicate abusive prescription practices, educate our communities about the dangers of these drugs, and treat those suffering from the grips of addiction.

We undoubtedly share those same goals, and I believe we have made some real progress together. But I also believe this request exposes our diverging paths to the promised land. We have got to continue to provide States the support they need to defeat the epidemic, but we have also got to do so within the reasonable confines of our budget.

Supplementing existing funding with mandatory dollars to fight substance abuse only hurts our ability to address the problem in the near and distant future. While the ideas behind this budget request merit consideration, the President's request is simply not feasible as written. So I hope we can work together to address my concerns because the stakes here are far too high for us not to.

Before I close, let me—I would be remiss if I didn't mention that rural hospitals across the country are struggling financially, and it is across the board. Many of them are on the brink of having to shut their doors, and I have several in my district that are at that stage, leaving these small communities without a dependable source of emergency and hospital care.

Instead of working with these hospitals to make sure rural Americans have affordable, reliable care close to home, some of the proposals in the President's budget will compound their financial troubles. These harmful proposals range from adding a user fee for hospitals that utilize the 340B drug pricing program to cutting the reimbursement levels for critical hospitals that oftentimes serve the chronically ill and elderly.

While to most it may seem like a few dollars here and a few dollars there, each proposal chips away at the sustainability of these rural hospitals. So I hope we can talk to you about that as time passes to solve a problem that is really crippling rural America fast.

I thank you for your work, and thanks for being here.

Secretary BURWELL. Thank you, Mr. Chairman. Thank you.

Mr. COLE. With that, I want to go to Mr. Dent, but before I do, after Mr. Dent enjoys a full 5 minutes, with unanimous consent, I am going to move us to 2 minutes. The Secretary has to get out

of here. I know she has an engagement. We want to try and help her.

But also there is a lot of questions here, and I want to give everybody a chance. So please, again, after Mr. Dent, we will try and hold it to 2 minutes. So thank you very much.

And with that, my good friend from Pennsylvania is recognized.

COLORECTAL CANCER SCREENING

Mr. DENT. Thank you, Mr. Chairman.

And good morning, Madam Secretary. We didn't get to hook up either, appreciated your phone call, though.

As you know, for several years, I have been working on legislation that waives co-insurance for colorectal cancer screening test for Medicare beneficiaries when the screening results in removal of tissue or a polyp. I am encouraged this year that the budget includes a recommendation to do just that.

How can we on the subcommittee continue to work with you and CMS to implement this common sense policy that we can further encourage more people to be screened for—

Secretary BURWELL. I think we are—

Mr. DENT [continuing]. Colon cancer, and what was the impetus for including this in this year's budget?

Secretary BURWELL. Thank you for your leadership and effort in this space. And I think we are hopeful that this is something that is a change that people could agree on as part of the budget process, and when we have put it in the budget, it is because we believe we need to help to get it done.

Mr. DENT. Well, good. I am pleased to see it in there, and it is something that we need to correct.

Secretary BURWELL. We look forward to working with you on it.

NIH FY 2017 BUDGET REQUEST

Mr. DENT. And my second question deals with the NIH issue, and I would like to discuss the discretionary funding cut the NIH faces in the proposed 2017 budget request. We provided NIH with a \$2,000,000,000 discretionary increase in 2016, and I was more than a little surprised that the 2017 NIH request reverses this with a \$1,000,000,000 decrease from NIH discretionary funds.

The request presumes to backfill these dollars with mandatory funds, which are outside the jurisdiction of this committee room. And we believe that is a truly unacceptable budget gimmick.

Further, it only assumes the mandatory funding for one year. In other words, it creates an out-year mandatory funding cliff of \$1,000,000,000 in fiscal year 2018 that our committee would have to address. Mandatory funding cliffs are one reason we appropriators do not support switching discretionary programs into mandatory funding.

The bill always comes back to rest at the doorstep for this committee to fix, and I certainly urge all NIH supporters, like myself, to avoid efforts to swap discretionary funding for mandatory funding streams. On top of this gimmick, the budget presumes to add another \$825,000,000 in mandatory funds for NIH to support the Cancer Moonshot, Precision Medical Initiative, and the BRAIN Initiative, all good programs.

Please discuss the impact on NIH if the authorizers don't act to provide mandatory funding. And specifically, how will this impact extramural investigator grants, success rates, and NIH's ability to sustain research supported with the \$2,000,000,000 increase provided this year.

Secretary BURWELL. So we are appreciative of the increase that we received, and I think this is about putting the overall budget together in terms and why we took these steps.

And I think in a world where—and this gets to Dr. Harris and some of his comments. In a world where we have a—one of the lowest discretionary as a percentage of GDP, which, when one thinks about your spending, thinking about the size of your economy, seems like an important way to measure.

And as we think about that, the question is if that is the path we want to choose in terms of our discretionary levels, and that is—part of that is in terms of what deal we did on the sequestration and the replacement of it, and do we think we are at the right discretionary level?

If we think we are at the right discretionary level, I think we wanted to stick with the agreement that we believe and have paid for. And one of the things that happens even when we do the agreements to raise the discretionary caps, often the pay-fors that we have in our budget are those that end up getting used.

And so I think the real question, and I am very appreciative, as my former role in OMB, of the issue with the discretionary and mandatory. So I am very appreciative of the concern and the questions that you are raising. I respect those.

But I think the larger question for all of us is do we believe that as a nation we are supporting the things that we need to support? And I think you know I came back to OMB with regular order, and I am so appreciative to Mr. Rogers and Ms. Mikulski for getting the first omnibus since 1987 in terms of regular order.

And so I prefer regular order in a world where that may not be people's first choice because they have concerns with discretionary levels. That is part of why we are doing it.

So I think what I am hopeful is that we, together, can have a real conversation. And that part of the conversation I think we can have because I think everybody is hopeful. I am so glad to hear all the hearings are going on. To me, that means regular order.

And so that means that, hopefully, we will get this done in a June/July timeframe, and this can be a part of that broader conversation in terms of, and it relates—NIH is one piece of the issues that Mr. Rogers raised.

Mr. DENT. I just want to conclude right now just to say that this is just one area where we are seeing mandatory programs—where funding is being diverted to mandatory programs. I have the same problem with the Veterans Choice Act. That funding is going to expire. It is going to fall on the Appropriations Committee to make it up in discretionary funds next year, but that is a subject for another day.

Thank you. I yield back.

Secretary BURWELL. But I think it does get to the broader issue and why I think we should have the broader conversation.

Mr. COLE. Thank you very much.

As my chief clerk adroitly reminded me, the chairman had not had 5 minutes. So, Mr. Chairman, whatever time you care to consume, you are welcome to consume. Everybody else will be confined to the 2 minutes when their turn comes.

CRITICAL ACCESS HOSPITALS

Chairman ROGERS. I will try to be very, very brief. The critical access hospitals, these hospitals face a unique set of challenges. In my rural district, we have seven critical access hospitals. Many of them are already struggling to keep their doors open.

What do you believe will be the impact of these reimbursement cuts that you are proposing will have on these hospitals?

Secretary BURWELL. So with regard to the issue of rural health care and rural hospitals, I think you know because of where I come from, this is an important issue overall. And so there are a number of places in the budget in terms of A&R regulations where the issue of what it does to rural communities, and we can go into some of those places. But with regard to this specific question, I think it is our thought that because these hospitals actually are receiving more in terms of Medicare payments than noncritical access hospitals, they will be in a place where the impact of this change is not something that overburdens them too much, and that is why the proposal is as it is.

But I think the broader question of how we support our rural hospitals is one that I think is an extremely important one. And throughout our budget, whether that is how we are thinking of providers in terms of some of our support for people that will tend to go to rural hospitals in terms of the public health funds that we do, to providers, whether it is how we are thinking about doing telemedicine and having Medicare Advantage.

One of our proposals is that Medicare Advantage would be reimbursed in terms of telemedicine so that we can use those facilities, and those rural hospitals can benefit from that. And so we are trying to think about the issue of rural hospitals overall.

Chairman ROGERS. Good.

Secretary BURWELL. And the other thing, while it is not an issue in your State, in other States, we have seen a larger closure of rural hospitals in those that have an expanded Medicaid. That is not, you know, an issue in your State.

PREVENTION OF OPIOID MISUSE, ABUSE, AND OVERDOSE INITIATIVE

Chairman ROGERS. Yes, thank you. Your opioid proposal is sweeping—

Secretary BURWELL. Yes.

Chairman ROGERS [continuing]. To say the least, and I am pleased that the request clearly recognizes and acknowledges the importance of our fight against drug abuse. But I am interested to hear your views on how these new pieces of the puzzle fit together.

Specifically, the degree to which the request relies on new mandatory spending, that part troubles me. For example, the budget allocates \$1,000,000,000 in new mandatory funding to SAMHSA and HRSA for treatment programs. Fifteen to 20 years ago, Oxycontin was just rearing its head in Appalachia. Certainly, my district was the headquarters of that.

Ten years ago, heroin was just a blip on the radar, but today opioid abuse has spread to every corner of the country. Cheap heroin is being laced with fentanyl, so strong that unsuspecting users die every day from overdose.

With the fight against drugs changing at the speed of light, it seems irresponsible to tie our hands with inflexible mandatory funding. We need to be agile and move with the times, adapting to the needs as they arise. The only vehicle that makes that possible really is discretionary spending so that we can help you adjust to whatever takes place as we march down this path.

What is your take on that idea?

Secretary BURWELL. First, thank you for your partnership and leadership. As you mentioned, we have worked on these issues together for a long time.

And with regard to the specific issue because we put most of the money in treatment, specifically medication-assisted treatment. I think you and I have discussed the strategy. I think it is a bipartisan agreement. That is important. Those monies will all go to States and communities mostly in terms of improving their infrastructure and ability.

Some of that is to train providers that would be—you know, you would want to continue, but that may be more one-time money. I think the question fundamentally, with regard to the medication-assisted treatment and the behavioral health issues, is historically in our country, we actually have had a situation where those are funded at the local level. And that is one of our biggest challenges right now, 85 percent of rural counties don't have behavioral health, and that is because often it is funded at the State and local level.

And so I think, as we think through this question about discretionary, mandatory, short-term, long-term, we actually need to answer whose responsibility do we believe that is? And I think we are going to face these questions. We face these questions in Flint, as Ms. DeLauro mentioned. We face these questions in behavioral health.

And whether that is the money we have put in for the 223 waivers that are part of that proposal or this. And so that, I think, is a part of the conversation we are going to need to have. Do we believe it should be the Federal Government's responsibility over the long term? And if we do, let us think about how we can find space on the discretionary side or lift those caps.

Chairman ROGERS. Well, we can continue to talk.

Secretary BURWELL. Thank you.

Chairman ROGERS. Thank you, Mr. Chairman.

Mr. COLE. Thank you, Mr. Chairman.

INDIAN HEALTH SERVICE

Madam Chairman, I am next, and I am going to be very brief in my questions, almost code, to give you as much time of my 2 minutes I can to respond. I will warn you these are matters I will be bringing up with you multiple times probably in the months ahead.

The first one, as you know, recently CMS flagged three Indian Health Service hospitals as "posing an immediate jeopardy to the health and safety of their patients." Those hospitals are under the

jurisdiction of your department. I take this very, very seriously. I have raised it with the Director of Indian Health this morning at an earlier hearing. I wanted to know that you are focused on this and you have a plan to deal with it.

WELDON AMENDMENT

The second question is the Weldon amendment. I am for a year and a half asked about—we get constant complaints that the State of California is not or is forcing institutions against their own conscience and creeds to perform procedures, abortions, that they don't believe in.

We have been told there is an ongoing investigation. It shouldn't take that long. They either are or they aren't. But I would like you to respond to that and tell me where we are in the investigation.

With that, I yield the balance of my time to you, Madam Secretary.

Secretary BURWELL. With regard to the second issue, when you and a number of your other colleagues contacted me and asked for an investigation to be opened, we opened that investigation. As you indicated, we are still in the middle of the investigation, and as I stated in the hearing yesterday, it has taken longer than I would like.

Because the investigation is still open and has not come to closure, I am not able to comment in terms of that. And in terms of setting a timeline, I am not able at this point to do that.

INDIAN HEALTH SERVICE

With regard to the Indian Health Service issues, it is a priority, and I look for your support as we work through it. Right now, we have changed the regional leadership. We have added a deputy for quality and a deputy for management, both at IHS.

And I have asked the Acting Deputy Secretary, Dr. Mary Wakefield, who ran HRSA, to have a cross-department effort so that we are bringing the best experiences of CMS, HRSA, SAMHSA, and any of the other best practices we have to increase the quality of the service that is being delivered at IHS because it is not satisfactory.

Mr. COLE. I appreciate that very much. This is an area we have actually increased funding since 2008 by 54 percent. It has been a really good bipartisan effort to try—

Secretary BURWELL. Yes.

Mr. COLE [continuing]. And get at the problems in Indian Country and, frankly, one that the administration can be very proud of its role. So I look forward to working with you on that.

And with that, I want to recognize my good friend, the distinguished ranking member from Connecticut.

Ms. DELAUBRO. Thank you, Mr. Chairman. Just a couple of points.

Labor, HHS is 32 percent of nondiscretionary spending. With that and our allocation last year, it should have been \$10,500,000,000. If we were to get the additional \$5,200,000,000 this time, we could avoid dealing with mandatory funds.

Very quickly, secondly, the prevention fund, Secretary has no flexibility over that prevention fund because for the last 3 years,

the Congress has made those allocations. We just ought to read the table.

OPIOID MISUSE, ABUSE, AND OVERDOSE INITIATIVE

Medication-assisted treatment. You are talking about your opioid initiative. I would like to have you talk about that. I had the opportunity to witness it firsthand at the New Haven Correctional Center a week ago.

PRESCRIPTION DRUG COSTS

Secondly, you have got some proposals on prescription drug costs, bringing that cost under control. I would like to have you just expand on that for a moment. The floor is yours.

Secretary BURWELL. I will do those backwards. As far as rising cost of prescription drugs, in this budget proposal, what you will see is we would like to move to close the donut hole faster, which will mean benefits. Right now, we have seen \$20,000,000 in benefits to 10 million seniors. We would like to speed that up as one of the things to help with the costs for individuals.

With regard to the overall cost, we have asked for authorities for specialty and high-cost drugs that we would have the authorities to negotiate.

OPIOID MISUSE, ABUSE, AND OVERDOSE DEATH

With regard to our opioid/heroin strategy, there are three main parts, and that is what the funding goes towards, these evidence-based strategies. The first is prescribing. We need to reduce the prescribing. You will be seeing CDC guidelines that will come out about prescribing. That is one of the things. There is some funding in the FY 2017 Budget Proposal to help support the implementation of those.

The second is medication-assisted treatment. That is where the vast majority of the funding goes because we know as an evidence base, that is the place. There are supplemental proposals in our budget that include things like who can prescribe buprenorphine. We hope you will review those budget proposals as well.

And the third element is naloxone or Narcan. And sadly, when people get to the place where overdosed, we must have tools for people to help them not die.

Ms. DELAURO. Mr. Chairman, I would hope we could have a hearing on the high cost of prescription drugs in this committee and during this period of time.

Thank you.

Mr. COLE. Thank you.

I next go to my good friend from Tennessee, Mr. Fleischmann.

CYBERSECURITY THREATS

Mr. FLEISCHMANN. Thank you, Mr. Chairman.

Madam Secretary, I am very concerned about the recent accounts of American hospitals and doctors' offices being the victim of ransomware and other cybersecurity attacks that have the potential to compromise or delete patients' personal health information

and other critical and sensitive data that our healthcare delivery system relies on.

I have two questions. What is the department doing in conjunction with other Federal agencies to address cyber threats to our healthcare system? And as a follow-up to that is, in your opinion, how serious is the ransomware threat, and what resources are you devoting to protect Medicare data from criminal security breaches?

And with that, I will yield the balance of my time to you, Madam Secretary, so you can address that.

Secretary BURWELL. So an extremely important issue, and actually, HHS is one of the—I think it has been stated even this week has been recorded as one of the lead departments on cybersecurity. We need to do it across the whole department, but I think you are focused specifically on CMS.

Some of the funds in our budget this time are very important funds to continuing our effort in cybersecurity. To answer your question about how important and how concerned we are about these issues, when I was confirmed on—for this job and had my first meeting with the issuers, everyone—it was June 9th, and so everyone thought I was going to talk about technology and the marketplace, which, of course, was a topic I should touch on, making sure we get that right.

But actually, the topic I also wanted to talk on was cybersecurity, and that was in June of 2014. I think this is an extremely important issue that we need to all work together on. I think we need the best practices from the private sector to learn from them, but I also think making sure we have a close tie and connection because when this happens, there are questions of breaches of information that could be HIPAA violations for individuals, depending on what those are.

And so making sure that we are working in a forum that we are doing our part as we can, learning from the private sector and making sure we are sharing as well. And that is not just at HHS. To your point, we coordinate with the FBI and others because when there is information that is important through DHS, we need to make sure that industry has information as appropriate around these issues.

Mr. FLEISCHMANN. Thank you, Madam Secretary. Appreciate your testimony today.

Mr. Chairman, I yield back.

Mr. COLE. Thank you very much.

I now go to my good friend from Philadelphia, Mr. Fattah.

EARLY CHILDHOOD EDUCATION

Mr. FATTAH. Madam Secretary, if we could turn our attention now to another part of your testimony today is around the Head Start and early education. So in Philadelphia, over \$300,000,000 in Federal—mostly Federal funds are used to provide Head Start and early childhood education, but we are still only reaching something slightly less than 40 percent of the children, and there is more to be done.

I appreciate the fact and will support the administration's request for \$9,600,000,000 in Head Start funds. I also note that you want to create a \$350,000,000 fund to work with States in terms

of preschool development grants. Can you talk a little bit about how those dollars would be used and distributed?

Secretary BURWELL. So as we think about this continuum and our early education home visiting. Thank you for the support in MACRA in terms of home visiting. But we think about home visiting, early education, preschool, and child care and Head Start. They are together—Head Start serves a particular population, but we want to make sure certainly in our child care proposal we are serving more.

In that early education money, those are monies that are generally targeted to more low-income communities through the States. And so some of those are for broader communities like child care, and Head Start and others are targeted more towards the low-income communities.

Mr. FATTAH. Thank you very much.

Can you talk a little bit about where you think—because you know the Pew Foundation, which is based in Philadelphia, has done a lot of work with States, and in fact, many of our State governments have been at the very forefront of this work. And I know the administration has taken a leadership around these first 1,000 days of a child's life. It is critically important in terms of the networking for the brain and for all of the health-related issues that are very, very important.

Talk about how you see the department's work now in conjunction and in working alongside of some of your colleagues like at the Department of Education and other—

Mr. COLE. Madam Secretary, you can talk about it, but be brief.

Mr. FATTAH. Oh, I am sorry. I forgot we were cutting it to 2 minutes. I will withdraw the question.

Secretary BURWELL. Thank you.

Mr. COLE. OK. Thank you very much. I appreciate that.

Dr. Harris, I don't know if you were here, but we are at 2 minutes.

Mr. HARRIS. Two minutes.

Mr. COLE. OK.

NATIONAL CANCER INSTITUTE

Mr. HARRIS. All right. Three very brief things. One, I am concerned, and I won't ask you to address it now. You know, we are almost one year out from—from the NCI Director announcing his retirement, and we still don't have an NCI Director. That is of concern for me, you know, when we are talking about Cancer Moonshots that, you know, the leading cancer person, his replacement hasn't been appointed.

Let me just mention one other thing. You know, the rosy assumption in the President's budget, of course, is 4 percent GDP growth. We haven't had 4 percent GDP growth in 10 years. In fact, as you know, the last quarter was 0.7 percent GDP growth. So that is a really rosy assumption.

And one of my concerns is that part of the Medicare savings, correct me if I am wrong, that is projected in your budget, that, you know, comes in under all—you know, balances, whatever you want to call it, is the change in the target rate growth from GDP plus 1 to GDP plus 0.5.

Is that right? That does achieve some of the savings?
 Secretary BURWELL. With regard, I will have to go back—
 Mr. HARRIS. The Medicare—

Secretary BURWELL. I will have to go back and check, Congressman. Some of these questions in terms of those are—are no longer—

Mr. HARRIS. Well, I am assuming, since it triggers the IPAB, the Independent Payment Advisory Board, at a lower rate, you must be making that to achieve savings, I would imagine. My concern again is with the Independent Payment Advisory Board. No one has been appointed to it.

It is going to be a rationing device, and I just hope Medicare beneficiaries realize what the—what your budget does to Medicare over the next few years.

ZIKA VIRUS RESPONSE

Finally, with regards to the Zika request, is it my understanding the administration said they actually want to use some of the Ebola leftover money for malaria last week?

Secretary BURWELL. Well, with regard to that, that is a question that would go to the State Department or USAID. Those are funds that are in their areas, not in mine.

Mr. HARRIS. So if that is true, the administration has already made a decision to use some of the Ebola monies for other diseases. And I would just suggest that that is what the State Department thinks they ought to do, that is what you ought to do for the Zika and not come in with a budget-busting \$1,800,000,000 request.

And I yield back the time.

Mr. COLE. Thank you.

The gentlelady from California is recognized for 2 minutes.

UNACCOMPANIED CHILDREN

Ms. ROYBAL-ALLARD. Madam Secretary, in your response to a question that was asked by my colleague Mrs. Roby, you said that it was your job to make sure unaccompanied children were safe. And so I was truly shocked to read about the release of unaccompanied minors from ORR in care into the hands of human traffickers, as was documented by the Permanent Subcommittee on Investigations in the U.S.

Can you tell me how much money is ORR requesting for home studies, which investigates the background of sponsors before children are released to them and post release services in which HHS can continue to check in on a child? And is the amount requested sufficient to take care of the anticipated number of unaccompanied children?

And if you have the time, if you could comment on the department's plan to continue and expand the pilot program where home studies are now required for all unaccompanied children 12 and under placed in Category 3.

Secretary BURWELL. The issue in Ohio is a tragic one of people breaking the law, and we will work with the Justice Department to do everything we can to the full extent of the law in terms of that tragic circumstance.

With regard to the overarching question of how we do this, there have been a number of improvements that we have made over time with regard to the safety of the children. And whether that is background checks on all adults who might be in the home, whether that is follow-up calls, whether that is 1-800 numbers, there are a series of those steps. I am happy to get those to you.

With regard to the funding issue, because of the unpredictability of the flows, as we discussed with Congresswoman Roby, our ability to do certain parts of this is dependent on the funding flows. Our ability to answer the question you asked would be enhanced greatly by having \$400,000,000—the contingency fund that we have put in. Because that way we could actually focus on if there is a flex, we would know where we would get that money, and we wouldn't use it unless we needed to flex. And then we could have surety of our money for the other services we provide.

Mr. COLE. Thanks very much.

The gentlelady from Alabama is recognized.

OFFICE OF REFUGEE RESETTLEMENT

Mrs. ROBY. Madam Secretary, I would appreciate, based on that last line of questioning, the opportunity to discuss that further with you. The GAO issued a report of the ORR, and it is quite concerning. They uncovered myriad problems regarding the handling of the detained minors—abuse, lack of oversight, a lack of control over the whereabouts and livelihoods of these minors.

So what I read in the Washington Post certainly, and I am sure you saw that article as well, doesn't give me any confidence about what is actually happening within the department, particularly if we have another influx, as is being predicted.

So what are your comments on GAO's findings, and how is your agency addressing the concerns that were outlined in the GAO report?

Secretary BURWELL. With regard to the specifics, as I said, we have made a number of improvements. But I would have to see which report at this point, in terms of the GAO report, the IG report, and I want to make sure I am referencing the right report. And so we can come back on that.

But a number of improvements are made with regard to the children. What I would say that is so important is our ability to focus on those issues is extremely important. We want that, and I think you know I came to the committee and asked for additional funding for this year, the year we are currently in, the fiscal year we are in, not the budget conversation we are having.

I asked. I sent letters. I talked to all four corners, all of those, because this ability to have standardized funding that we know we can depend on is a part of our ability to manage these problems well. And so that is the one thing as we are having this conversation especially around the budget that I think is extremely important.

We want to hear if people have suggestions for things we can do more. I think you have heard we have made a number of changes to make sure that we are checking the children, things are checked before.

You know, many of these children go to their parents here, and that is one of the issues that I think is an important one to recognize, that they are children. They make the journey, and they actually are placed with their parents. We still do checks in terms of that as well.

Mrs. ROBY. I yield back.

Mr. COLE. Thank you very much.

And for the last questions of the morning, I recognize the good gentleman from Pennsylvania, Mr. Dent, for 2 minutes.

BIOMEDICAL ADVANCED RESEARCH AND DEVELOPMENT AUTHORITY

Mr. DENT. I will keep it real quick. Thank you again, Dr. Burwell.

Just on the issue of BARDA, and I just wanted to make, I guess, a quick comment. It is my understanding that a vaccine platform, these technologies or these platform technologies could now be called upon to quickly develop a Zika vaccine and in general respond more expeditiously to the next outbreak or threat.

What is BARDA or HHS doing to support and facilitate platform-based technologies against known and emerging threats? And I mentioned Zika, but you know, there are other threats that are out there, obviously, from SARS, Ebola, H1N1 and H5N1, et cetera. So could you comment on that?

Secretary BURWELL. Right now, BARDA is a part of conversations that we are having with the private sector, and it is not just in the vaccine space. It is in the diagnostic space as well. Certainly for Zika, but for many other things as well, and so—and in the treatment place.

Mr. DENT. CDC, right? CDC doing the diagnostics or—

Secretary BURWELL. Ah, yes. CDC is doing the diagnostics, but we are really looking for private companies to actually take over manufacture of it because right now, it is all happening through CDC.

We also would like to see the private sector improve the technology. We have a technology. This is one of the difficult things about Zika. The diagnostic that is for you have the full-blown disease, it works pretty well. We know that you have Zika if you are symptomatic and we test you.

If you have passed and we want to test you—you went to Mexico, you came back. Eighty percent of people don't have symptoms, and we want to test you for that, that is a problem because we could show a positive, but you actually could have had chikungunya or dengue instead.

And so, our ability on that, so we are looking to the private sector as we advance. We will move as quickly as we can, but we are happy if the private sector can. So BARDA is playing an important role. In the supplemental, you will see funding asked for for that.

Mr. DENT. Thank you. I will yield back my last 18 seconds. [Laughter.]

Mr. COLE. I thank the gentleman for his generosity.

Madam Secretary, I want to—this is probably your last appearance before this subcommittee, although we will certainly have the opportunity to continue to work together for the balance of the year, which I look forward to a great deal.

And again, I want to echo and reinforce the sentiments of everybody on this committee on both sides of the aisle about how much we appreciate your service, what you have done, what I know you will do in the next year, what a delight it is to work with you. Frankly, how thorough and professional you are and, frankly, how much we will miss you in front of this committee, although I suspect you will not miss us very much. [Laughter.]

Mr. COLE. You have hardly been able to wipe the smile off your face as the minutes have ticked down. So I recognize that, but you will be missed by both sides of the aisle.

And thank you very, very much for your distinguished service to our country in a variety of capacities under two different administrations. It is something that you can take a great deal of personal pride in. It is something that, again, every Member on this dais certainly respects.

Secretary BURWELL. Thank you, Mr. Chairman. Thank you.

**Hearing on Fiscal Year 2017 Budget Request
From the Department of Health and Human Services
February 25, 2016**

Cole 1- Indian Health Service

I am deeply concerned about a crisis within the Great Plains Area of the Indian Health Service. Last year, the Centers for Medicare and Medicaid Services (CMS) terminated its agreement with the Omaha-Winnebago Indian Hospital, because the conditions at the hospital posed “an immediate jeopardy to the health and safety of patients.” Recently, CMS put two other Great Plains Area hospitals on similar notice. One of your agencies is telling another that three of its hospitals are dangerous, and yet they remain open for business. While I respect that the tribes want these facilities to remain open because there aren’t any better options, I would appreciate knowing that you are personally involved in an effort to use all of the resources at your disposal to correct serious personnel problems and make these hospitals safe again as quickly as possible.

- a) Are you personally involved?
- b) What is your plan?
- c) As a short-term solution to the reerruitment problem, will you please take a hard look at the U.S. Public Health Service Commissioned Corps and consider making deployment at Indian Health Service facilities a higher priority for the Corps?
- d) Employee accountability takes on a new meaning when lives are at stake. How are your personnel actions limited by rules that wouldn’t necessarily apply to caregivers at private hospitals?

Response:

- a. Yes, I am aware and greatly concerned by the situation in the IHS Great Plains Area, and that is why I have asked the most senior level of the Department, Acting Deputy Secretary Wakefield, to lead an HHS Executive Council on Quality Care (Council) to implement an action plan to improve quality and patient safety in the hospitals and clinics that IHS administers throughout the country, with an initial focus on the Great Plains Area. Acting Deputy Secretary Wakefield keeps me apprised of the situation and the related issues. The Council includes representatives from the IHS, Office of the Surgeon General, Centers for Medicare & Medicaid Services (CMS), Health Resources and Services Administration, Substance Abuse and Mental Health Services Administration (SAMHSA), and Centers for Disease Control and Prevention (CDC). HHS is leveraging resources throughout the Department to assist IHS in addressing problems at three Great Plains hospitals and implementing a series of reforms intended to stabilize, strengthen, and raise the overall quality of care in the region. IHS, with the support of the Department, is undergoing an aggressive effort to address the issues in the Great Plains Area. However, the challenges are longstanding and complex and sustainable change will require time and close attention beyond my time at IHS. We welcome and will need your support on this important priority.

- b. The Council is charged with developing and executing sustainable short- and long-term solutions for systematic improvement. Examples of specific initiatives include a rapid-response process to deploy resources from across the Department when a facility needs immediate, systematic improvement, options for providing technical assistance, and policy and training proposals to bolster the safety culture and practice. I have also asked the Council to establish a working group on IHS staffing shortages to generate innovative approaches and engage with the public and private sectors to help address longstanding medical and provider recruitment and retention issues in rural IHS facilities.

The U.S. Surgeon General has deployed Commissioned Corps Officers to the Great Plains Area to assist local IHS personnel in work underway to correct deficiencies found by CMS during reviews of Omaha-Winnebago, Pine Ridge, and Rosebud hospitals. These officers are already working alongside health care providers at the IHS hospitals and in the area office for at least the next three months.

As you know, the fiscal year 2016 appropriation for IHS included \$2 million to assist with accreditation emergencies. These funds have been distributed to the Omaha-Winnebago, Pine Ridge, and Rosebud hospitals to replace aging equipment, including a central monitoring system that will ensure reliability in one of the most critical systems.

I am also pleased to confirm that a 7,100 square foot behavioral health facility will soon be constructed in South Dakota. This facility will be staffed by at least 11 full-time behavioral health personnel, who will provide intensive outpatient therapy to suicide referrals, among other services, from the Great Plains Area, including Pine Ridge, Rosebud, Eagle Butte, and others.

In addition to deploying U.S. Public Health Service officers, new leaders have been brought onboard at the IHS regional and national levels. At the national level, IHS has established a new Deputy Director position to oversee an effort to ensure the agency focuses on quality improvement practices. At the IHS area level, the National Chief Medical Officer, Deputy Director of Field Operations, and a seasoned Area Director are detailed to the Great Plains Area Office for more intense local oversight and accelerated facility and Area Office change.

IHS is also transforming its Hospital Consortium into the Quality Consortium in 2016. It is led by an Executive Council of the Area Directors and Area Chief Medical Officers and coordinates activities aimed at improving the quality of care and enhancing patient safety. This level of oversight will lead to the development of the IHS as a high-reliability organization so that it actively learns and adopts evidence based practices. The consortium will work in consultation with tribal leadership and federal partners to finalize and implement the following initiatives in 2016:

- Establish a National Quality Managers Council to develop strategies to address areas for improvement observed across the system;
- Provide additional training for all facility governing boards and medical leadership;
- Use best practices to develop a governance model for local governing boards to follow;

- Standardize the credentialing and privileging process within IHS, so that area and service unit staff can track provider licenses and other certifications ;
- Review annually all accreditation surveys to identify hospitals and ambulatory facilities that need help most; and
- Utilize data analytics to drive better reporting and leadership decision making.

Close communication with Great Plains Area Tribes is also essential when designing and implementing services and programs needed by Tribes and their members. The IHS regularly engages the Omaha, Winnebago, Oglala Sioux and Rosebud Sioux Tribes in an effort to keep them fully informed of all activities related to health care for their tribal members and to include them in key decision making processes whenever possible

Our revised tribal Medicaid policy also will help improve the quality and access to care for American Indians/Alaska Natives who are already Medicaid eligible and receive IHS services. It also has the potential to improve health care for many more American Indian/Alaska Native residents who could gain access to health insurance coverage through Medicaid expansion. Medicaid expansion, if enacted in additional states, would not only strengthen coverage for American Indians in the state, but also diminish pressure on IHS resources, an effect we have seen in other IHS Areas comprised of states that have expanded Medicaid. I stand ready to assist with these policies and with other steps to improve the quality and access to care for American Indians.

- e. Yes, the U.S. Public Health Service Commissioned Corps have been deployed to the Great Plains Area to assist local IHS personnel in work underway to correct deficiencies found by CMS during reviews of Omaha-Winnebago, Pine Ridge, and Rosebud hospitals. These officers are working alongside health care providers at the IHS hospitals and in the area office for at least the next three months.
- d. The bylaws of a Federal hospital or clinic are utilized to restrict or remove the credentials and privileges of a medical provider when there is evidence of a deficiency in their competence or skills. This can happen rapidly, depending on the particular terms of the bylaws. However, there are due process requirements that must be met per the bylaws.

The ability to complete a disciplinary or adverse action against an employee for poor performance or misconduct within the Federal government is regulated by law, whereas employment in private sector hospitals is largely at will. Title 5, Parts 432 and 752 of the Code of Federal Regulations stipulates the applicable requirements related to adverse action, progressive discipline, advance notice, response timeframes required, and appeal rights afforded the employee involved. Taking action that does not conform to these requirements can lead to an appeal by the employee in question, and could be cause for returning an employee to duty. Additionally, for employees who are covered by a bargaining unit, provisions in the collective bargaining agreement may or may not add provisions that can also impact the success of a personnel action.

Federal employees also have a right to appeal to the HHS' Office of Inspector General; the Office of Special Counsel (OSC); and Merit Systems Protection Board, the Federal Labor

Relations Authority. Employees do not have the right to these forms of recourse in the private sector.

However, one challenge in the Great Plains Area has been an over-reliance on contractors due to difficulties finding and retaining clinical staff on a permanent basis. This staff does not have the same rights as federal employees. However, they can sometimes lack sufficient local knowledge and history with patients to provide the level of quality care that a permanent clinician can provide.

Cole 2- Public Health Preparedness

Recent events with Zika virus, Ebola, and other disease threats raise questions about what, if anything, we could be doing to be better prepared. New biological threats can emerge at any time and we must consistently invest in biosecurity preparedness to make sure we are not caught flat-footed.

Congress recognizes the importance of public health and preparedness. In FY 2016 we provided CDC an increase of over \$300 million (4%); Project BioShield was doubled from \$255 million to \$510 million; and BARDA received an increase of \$97 million (over 20% increase) to ensure we are leading in biosecurity and public health preparedness activities.

The FY 2017 request appears to provide inadequate funding for public health and preparedness against biosecurity threats by decreasing support for advanced development and procurement of needed vaccines and treatments with a 30% reduction to Project BioShield; level funding for BARDA, and reducing CDC.

Please describe how these requested levels will mitigate future biosecurity and public health preparedness risks and ensure our Nation stays in front of these types of event to protect all Americans?

Response

HHS is committed to working with Congress to support life-saving preparedness and response activities aimed at addressing chemical, biological, radiological, and nuclear threats, as well as other disasters, outbreaks, and epidemics.

We are appreciative of the increase in funding for the Assistant Secretary for Preparedness and Response (ASPR) provided in FY 2016 for Project BioShield (+\$255 million) and for advanced research and development (+\$97 million). The additional funding under Project BioShield will allow ASPR to support late-stage development and procurement of several new medical countermeasures (MCMs) to address multiple threats such as anthrax, smallpox, radiation/nuclear, and botulism. ASPR anticipates supporting five new MCMs under Project BioShield in FY 2016 for inclusion into the Strategic National Stockpile (SNS). These MCMs, along with the four new candidates that were supported in FY 2014 bring the total to nine new MCMs supported under Project BioShield. The additional advanced research and development funds will allow ASPR to address the public health threat of antimicrobial resistance and implement programs to address the Combating Antimicrobial-Resistant Bacteria (CARB) Action Plan. ASPR anticipates supporting new public-private partnerships with industry partners under the use of Other Transactional Agreements and to initiate a biopharmaceutical accelerator in collaboration with the National Institutes of Health to spur innovation in novel and non-traditional antimicrobials. Both streams of activity are seen as important steps in addressing the public health concern of antimicrobial resistance.

We are also appreciative of the CDC FY 2016 funding increase. In FY 2017, CDC requested \$1.4 billion for the Office of Public Health, Preparedness, and Response to protect the safety, security, and health of all Americans. The requested funding level is less than 1% below the FY 2016 appropriated level, a savings achieved by the proposed elimination of the Academic Centers for Public Health Preparedness. CDC will continue to support research and training for public health preparedness through other research activities within its Office of Public Health Preparedness and Emergency Response. Importantly, the request maintains funding for the SNS and the Public Health Emergency Preparedness (PHEP) cooperative agreement at FY 2016 levels. Recognizing the importance of

biosafety and biosecurity, CDC requested an additional \$5.4 million to improve regulation of select agents and toxins.

Project BioShield is a shared national security priority. The FY 2017 President's Budget will enable us to make meaningful progress on vital MCM procurements. Unlike a grant or research program that supports a steady and recurring level of effort, the Project BioShield budget is made up of a different set of discrete procurements in any given year when medical countermeasures are mature enough in development to meet Food and Drug Administration requirements for accessibility under Emergency Use Authorization.

In addition to the FY 2017 Budget request of \$350 million, the Department has obligated nearly \$50 million already for the purchase of anthrax antibodies out of the \$510 million from the FY 2016 appropriation and has plans to obligate the remaining balance to new MCMs (new anthrax vaccine, lyophilized smallpox vaccine, and radiation-related point-of-care biodosimetry devices) in the coming months. In FY 2017 the new resources will enable the Department to procure small quantities of a few additional chemical, biological, radiological and nuclear MCMs sufficiently mature for procurement, including

- New Ebola vaccines and immunotherapeutics for the prevention and treatment of Ebola infections;
- New high throughput biodosimetry devices to measure internal radiation exposure following a detonation;
- New antibiotics for the treatment of bacterial biothreats and high priority antimicrobial resistant bacteria;
- New diagnostics for the detection of anthrax in exposed persons; and
- Replenishment of anti-neutropenia cytokines for the treatment of radiation-induced blood illnesses.

The Biomedical Advanced Research and Development Authority (BARDA) within ASPR and the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) are committed to maintaining our national preparedness and making sure that MCMs are available when needed. Maintaining stockpiles of MCMs typically entails large procurement costs and is associated with substantial carrying costs. In an era of constrained resources, BARDA and its PHEMCE partners are mindful of the need to meet established requirements, sustain preparedness, and be good stewards of the taxpayers' investments. To this end, the PHEMCE is currently working to refresh the Material Threat Assessments that form the foundation for our requirements, many of which have not been reassessed in years. BARDA, for its part, emphasizes innovative approaches to total lifecycle cost-containment and strives to decrease the long-term costs of stockpiling MCMs.

One method is repurposing of commercial products and taking advantage of its commercial market, under vendor managed inventory (VMI). This method is currently being leveraged for cytokines to address neutropenia resulting from exposure to ionizing radiation. Another method that BARDA is employing is stockpiling of bulk intermediates. Bulk products do not have expiry associated with them like final drug products and can be maintained for longer periods of time. Stockpiling of bulk intermediates also allows BARDA to cut manufacturing times if additional product is necessary for a larger event.

Cole 3 - Obamacare Exchange Establishment Grants

The Affordable Care Act (ACA) allowed HHS to provide an estimated \$5.4 billion to the 14 states that desired to use the State Based Exchange program. The law does not allow these funds to be used for exchange operations and HHS is not allowed to issues grants after January 1, 2015.

I understand that at least \$1.2 billion was not spent as of 3rd quarter FY 2015.

These State-Based Exchanges have now been established. Please describe the timeframe and plan to recover any available State-Based Exchange Establishment grant funds back to the Treasury and how HHS expects to sweep up future funds that may become available in these States due to contract closure and other recoveries?

Response:

CMS reviews the State-based Marketplaces' proposed operating budgets to confirm funds are allocated according to federal requirements. CMS also follows established processes to monitor grant spending. Section 1311 grants are closed out once the grantee has completed all the work associated with a grant agreement or the end date for the grant has arrived, or both. As of November 30, 2015, over \$300 million of the 1311 funding awarded has been deobligated and returned to the federal government. In addition, Maryland has agreed to return \$32.5 million to the federal government due to their legal settlement with their contractor. CMS is in the process of collecting and returning more of the grant funds to the federal government through the grant closeout process, as well as through audits that identify any unallowable costs. In June 2015, CMS released FAQs to clarify the appropriate use of 1311 funds for establishment activities.¹

¹ <https://www.cms.gov/CCIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL-1311-FAQ-06-08-15.pdf>

Cole 4 - NIH Mandatory Funding Cliff

I'd like to discuss the discretionary funding cut the NIH faces in the proposed 2017 budget request. We provided NIH with a \$2 billion discretionary increase in FY 2016 and I was more than a little surprised the FY 2017 NIH request reverses this with a \$1 billion decrease from NIH discretionary funds. The request presumes to backfill these dollars with mandatory funds, which are outside the jurisdiction of this committee -- truly an unacceptable budget gimmick.

Further, it only assumes the mandatory funding for one-year. In other words, it creates an out-year mandatory funding cliff of \$1 billion in FY 2018 that our committee would have to address. Mandatory funding cliffs are one of the reason we appropriators do not support switching discretionary programs into mandatory funding.

On top of this gimmick, the budget presumes to add another \$825 million in mandatory funds for NIH to support the cancer moonshot, precision medicine initiative, and the BRAIN initiative.

- a) Please discuss the impact on NIH if the authorizers don't act to provide mandatory funding?
- b) Specifically, how will this impact extramural investigator grant success rates and NIH's ability to sustain research supported with the \$2 billion increase provided this year?

Response:

HHS thanks the Committee for the \$2 billion discretionary increase that NIH received in FY 2016. The President's Budget requests \$33.1 billion for NIH, an increase of \$825 million, to advance our shared commitment to support innovative research. This request includes \$1.8 billion in new mandatory resources in order to provide a total for NIH that not only maintains the significant increase enacted by Congress in FY 2016, but also provides resources for new high-priority projects including cancer research, precision medicine, and the BRAIN Initiative. Without the additional funding requested, NIH would be unable to sustain the progress being made this year or to ramp up these and other initiatives to meet the long-term goals.

If funding for NIH were not included at the President's Budget request level, it would affect every area of medical research. NIH would award fewer new and competing research project grants, and would have to scale back research projects started in FY 2016 and prior years. At a time when the success rate is near a historic low, it would be a step in the wrong direction. We look forward to working with this Committee as you consider the funding request, and all that we can accomplish in the years ahead. We welcome the support to work with you and others to create sustainable funding paths for NIH and the rest of the Department.

Cole 5 - PHS Evaluation Set-Aside (a.k.a. TAP)

HHS is authorized to “tap” PHS Act authorized programs in order to conduct program evaluations. In recent years, the funds have been used to support program activities as well. Last year I mentioned that we need to be more transparent in the way HHS programs are funded, and we need to return the tap to its original purpose of program evaluation and original, authorized level of one percent.

We had hoped our concerns would result in a budget request that begins to unwind the use of “tap” beyond its original purpose. However, again the request goes in the opposite direction -- proposing to take the “tap” up to 3 percent - effectively moving around more than \$1.4 billion of resources through a less than transparent budget gimmick. Can you provide us with a plan that will take significant steps to bring the use of “tap” back to its original intent of 1% for program evaluations?

Response:

The Public Health Service (PHS) Evaluation Set-Aside is authorized by section 241 of the PHS Act, which has been amended in appropriations bills and authorizes HHS to assess a percentage of PHS Act authorized program funding to support critical public health and evaluation activities across the Department. Initially, the PHS Evaluation Set-Aside was set at 1% and designed to make funding available for the improvement of programs and services through the collection of information on program performance. For many years now, the Congress has increased that percent (to 2.5% in FY 2016) and has directed the resources available for agencies across the Department in appropriations bill language.

The FY 2017 President’s Budget proposes an increase of the PHS Evaluation Set-Aside from 2.5% to 3%, consistent with the approach taken in the FY 2016 President’s Budget, and transparently reports how this funding would be used, both in program level totals and in appropriations language. Activities are excluded from the set-aside because they are not PHS Act authorized, they support program management, or they have been consciously excluded by Congress (e.g., the SAMHSA block grants). The Department examines sources and receivers during the annual budget process and reports to Congress its plans for using the PHS Evaluation Set-Aside authority to fund critical activities.

Cole 6- World Health Org (WHO) Dairy Guidelines

We understand that on January 15, 2016 the World Health Organization (WHO) issued draft “Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children.” The guidance proposes to establish significant new restrictions and prohibitions on the promotion and marketing of milk products (including follow-up formulas, milk, cheese and yogurt) for young children up to three years of age without providing any evidence, scientific substantiation or an impact analysis to justify the measures.

I don’t understand the logic of these recommendations, as we continue to hear that milk and milk products are good for our health. The HHS Dietary Guidelines notes a healthy eating pattern includes...fat-free or low fat-free dairy, including milk, yogurt, cheese, and/or fortified soy beverages. The HHS guidelines apply to individuals age 2 and older. The WHO appears to contradict the nutrition’s food provided to children under three in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

- a) Does HHS support these WHO draft guidelines? Why?
- b) What is HHS’s role in influencing WHO in this process?
- c) How can work together to ensure the WHO is developing science-based guidance to prevent unintended negative health consequences for young children and potentially violate World Trade Organization (WTO) trade rules, including imposing restrictions on the use of intellectual property by brand owners.

Response:

At the request of Member States, the World Health Organization (WHO) developed draft guidance on ending the inappropriate promotion of foods for infants and young children.²

The WHO developed this guidance using a Scientific and Technical Advisory Group process. Convened in 2013, the Scientific and Technical Advisory Group produced several reports, including a draft of the guidance that they presented to WHO in 2015. Following online and in-person public consultations, the WHO presented revised draft guidance to Member States at the WHO Executive Board meeting in January 2016. Following the meeting, the WHO opened an additional consultation period in February 2016 to allow time for further Member State comment. The guidance is not binding on Member States.

The WHO draft guidance advises Member States on ending inappropriate promotion to consumers of foods for infants and young children. The draft does not seek to prohibit the marketing of all milk products consumed by young children, to limit product availability, or to revise recommendations for optimal infant and child feeding practices. The document does recommend that countries prohibit the promotion of breast-milk substitutes marketed for feeding children up to three years of age.

As the agency representing the United States to WHO governing bodies, HHS submits feedback to WHO and represents U.S. policy perspectives. HHS is working with other relevant federal agencies to prepare a technical comment submission to WHO, and has had multiple conversations with

² As presented in report EB138/8: Maternal, infant and young child nutrition. Available at http://apps.who.int/gb/ebwha/pdf_files/EB138/B138_8-en.pdf (Accessed March 14, 2016).

stakeholders on the matter. HHS has not taken a position on the draft guidance on inappropriate promotion, pending clarifications from WHO following the February consultation period. HHS supports the effort to make evidence-based recommendations on public health, including child nutrition, and will continue to work with the other agencies and discuss remaining concerns with stakeholders.

Cole 7- Conscience Protection "Weldon amendment"

My question is concerning the "Weldon amendment" which has been carried in the Labor HHS bill since fiscal year 2005. The amendment prohibits funding to any federal, state or local government that discriminates against a health plan for refusing to cover abortion. The Obama administration issued regulations designating the HHS Office for Civil Rights to enforce the Weldon amendment by receiving complaints of any violations.

As you are well aware, complaints have been filed by several entities from the state of California alleging violation of this amendment. The FY 15 and 16 Omnibus bills included language asking the Office for Civil Rights to respond to complaints expeditiously, yet to date no action has been taken, nearly a year and a half after initial complaints were submitted.

Please tell us the status of this investigation, why it is taking so long, and when should we expect your Department to enforce the law?

Response:

The Department takes our responsibilities under the Weldon Amendment seriously, and HHS supports clear provider conscience clause protections. As you know, the Office for Civil Rights currently has open investigations related to complaints of Weldon Amendment violations. We cannot comment on the status of this particular investigation because it is still an open case.

Cole 8- HHS OIG Report “Federal Marketplace”: Inadequacies in Contract Planning and Procurement

Please provide an update on the progress made to implement the recommendations that came from the HHS OIG report on “Federal Marketplace”: Inadequacies in Contract Planning and Procurement. Specifically, describe specific action taken to strengthen accountability and steps to review the applicability of the recommendations to other agencies within HHS.

Further, please provide a timeline and the estimated cost to implement all the OIG recommendations.

Response:

CMS is working to ensure effective management of the Marketplace with a focus on clear lines of authority, prioritization of requirements and deliverables, and metric-driven quality reviews for its HealthCare.gov contracts and for contracts across the agency. A task force was established to develop a program-wide view of the cost of the Marketplace in order to strategically manage Marketplace acquisitions. Additionally, CMS is enforcing a strict governance structure for contracts and is strengthening its training for its acquisition workforce. CMS has brought in new leadership to oversee the Marketplace, with an eye on focusing on Marketplace operations such as contract management. CMS is working to develop a strategic and unified view of the Marketplace and its other major IT contracts and costs.

CMS is taking the HHS OIG's findings and recommendations seriously, and is using the report as an opportunity to make change. CMS has or is in the process of implementing all of the OIG's recommendations. CMS anticipates that it will be able to implement these recommendations within its current resources.

Cole 9- Exchange Cyberattack Procedures:

Please provide an update on steps taken over the past year and planned over the next year to strengthen potential cyberattack relative to the Exchanges and HHS procedures. Specifically, please address plans to encrypt consumer data used to support the Exchanges (Federal and State) and Exchange insurance plans. Further, detail the approach HHS will take if the systems are hacked or an unauthorized release of Exchange related data were to occur.

Response:

The Centers for Medicaid & Medicare Services (CMS) developed HealthCare.gov and its related Marketplace systems consistent with federal statutes, guidelines, and industry standards that help safeguard the security, privacy and integrity of the systems and the data that flow through them. CMS has implemented robust security controls to protect personal information, including ongoing penetration testing consistent with industry best practices. As part of the ongoing testing process, and in line with federal and industry standards, any open risk findings are addressed with risk mitigation strategies and compensating controls. The security of the system is also monitored by sensors and other tools to deter and prevent unauthorized access. CMS conducts continuous monitoring using a 24/7, multi-layer IT professional security team, added penetration testing, and ongoing testing and mitigation strategies implemented in real time. In addition, HealthCare.gov's internal data warehouse is on an isolated network, accessible only by authorized HHS employees and contractors. The data warehouse uses strong authentication, encryptions, firewalls, and secured operating systems to restrict access to the system. CMS has implemented security controls and reviews, including ongoing penetration testing and automated scanning, consistent with FISMA requirements and industry best practices. As part of the ongoing testing process, and in line with federal and industry standards, any open risk findings are addressed with risk mitigation strategies and compensating controls. Marketplace IT systems are continuously monitored by sensors and other tools to deter and prevent unauthorized access.

To date, no person or group has maliciously accessed personally identifiable information through HealthCare.gov or supporting systems.

Cole 10- CMS Request for FY 2017 Questions:

- a) Please provide the specifics on how the participation in RAC appeals will breakout and the projected impact on the appeals turnover rate and impact on the number of appeals filed based on this initiative?
- b) Please explain why the Oversight and Management of Marketplaces program requires Program Management support in lieu of support via the user fee.
- c) How much of the funds being requested by CMS (and in which accounts/sources) are being used to support processes with IRS to allow the Exchanges to ensure identification of individuals who did not provide accurate estimates in the prior year based on reconciliation with IRS tax filing data?
- d) Please provide the annual average cost CMS (using all sources) obligates (including admin time) to pay for Consumer Outreach for each cohort of beneficiary 1) Medicare; 2) Medicaid; and 3) Enrollee in the Exchange for each FY 2015, FY 2016, and FY 2017. Plus, provide the average industry cost of an insurance plan in the exchange for marketing and outreach cost and the industry average for a private market plan not in the exchange for each of the same years. Finally, what is the total cost of funds to be spent on the activity from all CMS sources (including collections) for FY 2015, FY 2016, and FY 2017?
- e) Please provide a table that shows the full cost for each of FY 2015, FY 2016, and FY 2017 of the ACA Marketplace backend functions (to include IT costs). Please include annual percentage status of operational readiness for these functions.

Response:

- a. When CMS participates in an Administrative Law Judge (ALJ) hearing at the Office of Medicare Hearings and Appeals, data demonstrates that the ALJ is less likely to decide in favor of appellants. In addition, both CMS contractors and appellant providers have stated that when CMS participates in a hearing, there is an opportunity for both sides to learn from each other which improves future billing and lower level appeal review. CMS' FY 2017 Program Management request includes funding to increase CMS participation in ALJ hearings. The number of cases that CMS can participate in based on that increase is dependent upon the type of cases (e.g., Part A inpatient, Part B durable medical equipment, etc.) pending before the ALJ. However, any increase in participation will potentially facilitate the overall reduction in the overturn rate at the third level of appeal and potentially reduce the incentive for appellants to bring appeals to the third level.
- b. The Centers for Medicare & Medicaid Services (CMS) is permitted to collect user fees for Marketplace-related activities that it performs in lieu of a state. For each benefit year, the FFM user fee rate is established in the Annual Notice of Benefit and Payment Parameters (Payment Notice) using projected enrollment and premium estimates, and contract costs for services provided to FFM issuers. The cost to operate the FFM includes both fixed costs and costs that vary by number of participating states, issuers, and enrollment. Activities eligible for user fees are related to costs incurred to CMS to provide special benefits to issuers participating in the FFM. Eligible costs include activities such as eligibility determination, QHP certification, enrollment processes,

consumer assistance tools, outreach and education, oversight of navigators and agents/brokers, and Small Business Health Options Program (SHOP) functions. CMS has requested appropriated funding for activities that are not user fee eligible and are inherently CMS' responsibility, such as the Data Services Hub, payments to issuers, and most eligibility appeals. CMS will require appropriated funds for continued operations of those activities in the future.

- c. CMS does not break out funding amounts related to coordination with IRS on determining eligibility for advance payments of the premium tax credit, but these costs are reflected primarily in the requests for Payment and Financial Management as well as Eligibility and Enrollment.
- d. HHS is committed to working with consumers to help them understand their options for quality, affordable health coverage. The table below provides total CMS consumer outreach obligations for Medicare, Medicaid, and the Marketplace excluding the consumer call centers and web portal. The table below summarizes consumer campaign funds:

Consumer Outreach by Program

<i>in millions</i>	FY 2015 Actual	FY 2016 Spend Plan*	FY 2017 PB
Total Medicare (Program Operations)/1	\$68.4	\$51.3	\$87.3
Total Medicaid (CHIPRA/MACRA)	\$4.5	\$39.7	\$0.4
Total Marketplace	\$157.3	\$141.7	\$167.5

/ The HHS Administration for Community Living runs the State Health Insurance Assistance Program (SHIP) that includes targeted outreach to Medicare eligible beneficiaries. Program cost is approximately \$52 million.

**These are estimates and subject to change.*

CMS does not track industry average costs for marketing and outreach of private health insurance plans.

- e. The total amount for the FFM IT system, also called FFM HIX, is shown in the table below. This system supports not only the back end payment functions, but also eligibility and enrollment, qualified health plan display, and SHOP functions. CMS does not separately track expenses related to the payment functions within the FFM HIX. Beginning in January 2016, CMS implemented policy-based payments, representing completion of the major back end systems, though continued development is expected in FY 2017 to improve consumer responsiveness of the FFM IT system and HealthCare.gov

<i>in millions</i>	FY 2015 Actual	FY 2016 Spend Plan*	FY 2016 PB

Total Cost of FFM HIX	\$163.6	\$137.0	\$154.3
-----------------------	---------	---------	---------

*This is an estimate and subject to change.

Cole 11- ObamaCare FY 2017 Funding

- a) Please provide specific details on how CMS expects to use all the funds requested and the offsetting collections to support ObamaCare activities funded in the CMS Program Management account? Specifically, what are these funds to be used for?
- b) What is the current assumption of ObamaCare related Offsetting Collections for CMS Program Management in FY 2015, 2016, and FY 2017 given new knowledge on enrollment since the budget was released? Please describe what these funds were used for in FY 2015 and projected for FY 2016 and FY 2017.
- c) What is the current estimate from all sources that CMS will use to support ObamaCare activity in FY 2016 and FY 2017 (include the FY 2015 actual for each source)? Please provide an itemized list of activities with the cost and amount of funds obligated or planned for each year? Please ensure it includes funds transferred in from other agencies, offsetting collections, etc (all sources).
- d) Please provide a breakdown of the total amount of CMS Program Management Funds to be used to support ObamaCare Activity in FY 2015, 2016, and 2017, with a breakdown of the activities supported and amount per year.
- e) What are the assumptions used to develop the FY 2017 budget request for ObamaCare in FY 2017; to included enrollment, participating providers, states using the federal exchanges, and other key assumptions? Please provide the specific number and attribute for each as well as how it calculated in to the total request. Further, provide the FY 2015 and FY 2016 data for each FY 2017 assumption.
- f) How much do you expect the full cost of implementation of ObamaCare from when it passed to complete implementation to cost the taxpayer?
- g) What steps have you put in place to ensure there is full accountability for all the ObamaCare funds and how do you validate that these funds are spent appropriately?
- h) Does the FY 2017 request for CMS Program Management assume:
 1. Use of the Implementation Fund? If so, how much?
 2. Use of the Nonrecurring Expense Fund (NEF)? If so, how much?
 3. Use of the HHS 1 Percent Transfer Authority? If so, how much?
 4. Use of Prevention and Public Health Fund? If so, how much?
 5. Realignment of any FY 2016 CMS Program Management Funds being used for non-ObamaCare activities? If so, how much?
 6. Use of the special funds provided to CMS for traditional Medicare activities in the FY 2016 Appropriations Act General Provision? If so, how much?
 7. Use of any mandatory funds to support CMS Program Management activities related to ObamaCare? If so, how much?
- i) Please describe if HHS assumes any Risk Corridor receipts to be collected and out of the CMS Program Management account and the source of any outlay funds in FY 2016 and FY 2017. Further, what is the assumption of how HHS will fund any expected shortfalls for the Risk Corridor program in FY 2015, FY 2016, and FY 2017? If HHS expects to use mandatory funds, please provide the legal opinion to justify such action? Can these requirements be shifted to another fiscal year? And finally, what is the impact of the program if these receipts are not at the anticipated requirement level?

- j) Please describe the mechanisms in-place to ensure fiscal responsibility of the state exchange funds and the funds used to support the federal exchange? What is changing in FY 2016 and FY 2017 to increase oversight?
- k) Please describe the Transition Reinsurance Program, cost, and how the ObamaCare would be impacted if this particular activity did not exist? Please provide the same for Risk Adjustment Program and separately for the Risk Corridors activities. Please describe how the HHS interpretation of these programs have changed since enacted.
- l) How much money are you requesting from this subcommittee in FY 2017 to support Obamacare Marketplaces as compared to FY 2016?
- m) What other sources of funding does your budget assume will be used to support the Marketplaces in FY 2017? For example, do you plan to use funds from the Nonrecurring Expenses Fund in FY 2017 to support Obamacare? How much? Do you plan to use your 1% transfer authority to move money out of biomedical research and public health activities to support administration of Obamacare has been done in the past?
- n) If user fees do not meet your estimates, will HHS seek additional funding to administer the Marketplaces program from this Subcommittee?

Response

- a. The Marketplaces provide affordable, quality health insurance options at a range of coverage levels. On behalf of all Marketplaces, CMS provides consumer eligibility verification services for financial assistance or other health insurance programs via connections to trusted data sources through the Data Services Hub; payment of financial assistance to issuers when a consumer is eligible; development of a quality rating system; oversight of State based Marketplaces; and operation of the permanent Risk Adjustment and temporary Risk Corridor Program.

When a State elects not to operate its own Marketplace, CMS performs certification and oversight of qualified health plans; agent and broker training; enrollment activities; appeals; and consumer assistance and outreach. States may also separately elect for CMS to operate the Small Business Health Options Program (SHOP). State Based Marketplaces may partner with CMS to leverage Federal resources, such as enrollment, through an arrangement called State-based Marketplaces operating on the Federal Platform (SBM-FP).

CMS operates a number of IT systems in support of Marketplaces. These systems provide core Marketplace functions including enrollment, plan management, and financial management.

Page 361 of the FY 2017 CMS Congressional Justification provides additional information on costs by activity.

- b. In FY 2015, CMS collected \$888 million in offsetting collections for the Federally-Facilitated Marketplace (FFM) and risk adjustment. In FY 2016, CMS is currently estimating \$1.2 billion in offsetting collections rising to \$1.61 billion (pre-sequester) in FY 2017. Offsetting collections will continue to fund activities that would otherwise be performed by a state if it were operating a Marketplace including activities related to QHP certification, enrollment

processes, consumer assistance tools, outreach and education, oversight of Navigators and agents/brokers, and SHOP Exchange functions.

c.

**Marketplace Sources FY 2015 to FY 2017
(dollars in millions)**

Funding Source	FY 2015 Actuals	FY 2016 Spend Plan*	FY 2017 Budget
Program Management	\$1,057	\$755	\$535
Nonrecurring Expenses Fund	190	-	-
User Fees/ ¹	879	1,225	1,610
Other	19	18	-
Total	\$2,145	\$1,998	\$2,145

Totals may not add due to rounding.

* FY 2016 spend plan includes estimates that are subject to change.

/1 User fee totals include reinsurance administrative collections and risk adjustment user fees. Projected user fees for FY 2016 and 2017 are based on estimates and are subject to change.

Page 361 of the CMS Congressional Justification provides cost information for the following Marketplace activities from FY 2010 to the present: Federal Payroll and other Administrative Costs; Marketplace-related Information Technology (IT); Non-IT Program Costs, including Health Plan Benefit and Rate Review, Marketplace Oversight, Payment and Financial Management, Eligibility and Enrollment; Consumer Information and outreach, including the Call Center, Navigator Grants and Consumer Education and Outreach; Marketplace Quality Review; Small Business Health Options Program and Employer Activities; and other Marketplace Activities.

- d. Total CMS obligations for the Marketplace from Program Management in FY 2015 were \$1.06 billion. The approximate break down per activity was \$80 million for Federal Administration costs, \$113 million for consumer outreach activities such as the call center, \$226 million for eligibility and enrollment activities, \$32 million for plan management activities, \$497 million for information technology activities, and the rest for activities to support the Federally-facilitated SHOP, payment management functions and technical assistance to stakeholders. The FY 2016 and FY 2017 Program Management funding for Marketplaces will support payment and financial management, enrollment, outreach and education, information systems operations, and Federal Administration costs.
- e. CMS assumes operating individual Marketplaces for 35 states in 2017, up from 34 states in 2015 and 2016 in addition to four State-Based Marketplaces operating on the Federal platform through HealthCare.gov. During the 2016 Open Enrollment, 9.6 million consumers selected health insurance plans through HealthCare.gov, and CMS estimates modest growth in for FY 2017. Although many of the Federally-facilitated Marketplace operations are workload-driven, there is not a one-to-one correlation of increased enrollment to workload and associated costs. The FY 2017 request represents an assessment of needs.

- f. From enactment of the law through FY 2013, HHS obligated just under \$2 billion to implement the Federal Marketplaces. Federal Marketplaces became operational in FY 2014 with the initial open enrollment, and CMS obligated approximately \$2 billion for operational and continued development costs in that year. CMS expects to obligate roughly \$2 billion on Federal Marketplace operations annually, reflecting the ongoing operational costs of a complex, nation-wide program, and the majority of costs will be funded through user fees.
- g. HHS is committed to the responsible, transparent use of taxpayer dollars to implement the ACA and the Health Insurance Marketplaces. Funding for Marketplaces is subject to the same types of financial controls that CMS employs for compliance with OMB Circular No. A-133 and government accounting standards in its other programs. CMS is also subject to a separate audit as part of the HHS-wide Chief Financial Officer's audit.
- h.
 - 1. No
 - 2. No
 - 3. No
 - 4. No
 - 5. CMS has accounted for all Program Management funds as part of the request.
 - 6. No
 - 7. No
- i. Additional risk corridors payments for the 2014 program year will be paid out of program year 2015 risk corridors collections, and if necessary, program year 2016 collections. As we have said previously, in the event of a shortfall at the conclusion of the three-year risk corridors program, the agency will work with Congress to provide necessary funds for outstanding payment. We will not know the total loss or gain for the program until the fall of 2017, when the data from all three years of the program can be analyzed and verified.
- j. CMS reviews the State-based Marketplaces' proposed operating budgets to confirm funds are allocated according to federal requirements. CMS also follows established processes to monitor grant spending. Section 1311 grants are not available for ongoing state operations of Marketplace functions, and CMS will close out existing grants once all the work associated with a grant agreement or the end date for the grant has arrived, or both. As part of the close out process, CMS reviews and audits state costs associated with the grants to identify any unallowable costs. CMS conducts oversight of SBMs to ensure they meet national standards for certification and have appropriate financial plan in place. SBMs are responsible for developing revenue plans that are sufficient to meet their operational costs.
- k. Reinsurance: The transitional reinsurance program which began in 2014, is designed to reduce the uncertainty of insurance risk in the individual market by partially offsetting issuers' risk associated with high-cost enrollees. In the absence of this program, insurers would bear the full cost of claims for high-cost enrollees for the initial years of the Affordable Care Act's market reforms (2014-2016 benefit years), and would likely pass these costs on to consumers, resulting in sharp premium increases in the individual insurance market.

Risk Corridors: The purpose of the risk corridors program is to protect against pricing uncertainty in the Marketplace until issuers have better information about the newly insured and can set appropriate premium rates for this population. The program, which was modeled after a similar program implemented as part of the Medicare Part D prescription drug benefit program, encourages issuers to keep their rates stable as they adjust to the new health insurance reforms in the early years of the Marketplaces.

Risk Adjustment: The Affordable Care Act establishes a permanent risk adjustment program to mitigate the effect of risk selection on premiums. It does this by transferring premium revenue from plans with below-average actuarial risk to plans with above-average risk, in a budget neutral manner. Because the program is designed to be budget neutral, and funds collected from issuers used to pay other issuers, an appropriated funding source is not required. Risk adjustment is critical to making the ACA's better-known market reforms work well for insurers and consumers. By reducing incentives for issuers to try to design products that attract a healthy risk pool, risk adjustment lets issuers compete on quality, price, and products that meet the needs of all consumers, protecting consumers' access to a range of robust options.

- l. CMS is requesting a total of \$535 million in FY 2017, a reduction of \$94 million from the FY 2016 request of \$629 million. In addition, CMS anticipates collecting \$1.6 billion in user fees to comprise a \$2.1 billion program level for FY 2017.
- m. The President's Budget request only includes Program Management and offsetting collections from authorized user fees.
- n. CMS estimates collecting \$1.6 billion in user fees in FY 2017. Current collections for FY 2016 are on track to reach our estimated amount of \$1.2 billion when including risk adjustment fees. If available resources are not sufficient to support Marketplace activities, HHS will evaluate all available resources and options at that time.

Cole 12- Nonrecurring Expense Fund

- a) What is the maximum amount of funds that could be available for the NEF in FY 2017?
- b) What is the FY 2017 budget request assumed for the NEF funds, please include the assumed levels for and used levels for FY 2015 and FY 2016?
- c) Please provide a table with every program supported over the years of NEF authority with the level noticed to Congress, actual obligations by year, and any unobligated level available by project and total for each year?
- d) What is the maximum level of NEF funds that could be swept up under this authority? Plus, include a breakout that adds in any prior year funds not obligated or needed for the specific programs that are complete or have lower cost estimates.

Response:

- a. As we reach the end of the fiscal year, more reliable and precise estimates can be made regarding the level of unobligated balances which may be transferred into the NEF, which is the primary driver in determining budget levels for the following fiscal year.
- b. For FY 2015, the Department notified the Committees on Appropriations on February 13, 2015 for \$650 million in planned uses of the NEF, and obligated \$427 million as of February 2016. For FY 2016, the Department notified the Committees on Appropriations on November 19, 2015 for \$570 million in planned uses of the Nonrecurring Expenses Fund (NEF). FY 2017 NEF funds and plans are still under development. As we reach the end of the fiscal year, more reliable and precise estimates can be made regarding the level of unobligated balances which may be transferred into the NEF, which is the primary driver in determining budget levels for the following fiscal year. The variable and unpredictable nature of eligible balances for the NEF comes from the requirements in statute to maintain expired unobligated balances in accounts for routine adjustments to previously recorded obligations. As an account nears its time of cancellation, HHS is able to identify amounts to transfer.
- c. See attached table, all obligations are as of February 2016.
- d. Funds are transferred to the NEF only as they reach the cancellation period. As such, the maximum amount eligible for transfer to the NEF cannot be fully determined until the end of the fiscal year. The Department expects to obligate the full amount of prior notifications, but the timing of such obligations is dependent on contracting procedures and therefore variable.

Cole 13- IHS Block Grant Programs

- a) HHS Administers 10 block-grant programs through its various agencies. Often, this money is distributed to states, who then pass the funds to other areas in their jurisdiction. The Committee has heard from Tribal communities that they are often left out of block grant funding from states or have to meet specific criteria at odds with their status as sovereign nations. Please provide the Committee a table of the following:
 - 1) Name the specific HHS blocks grants that allow the direct funding of Indian Tribes /or Tribal organizations.
 - 2) Which block grants are currently funding Tribes directly?
 - 3) Which grants funding Tribes indirectly through state pass through funds?
- b) Please provide a table that identifies what resources are available from HHS for Tribes who wish to apply directly for block grant funds in FY 2015, FY 2016, and FY 2017?

Response:

The Administration has made tribal consultation a priority by continuing to meet with tribal leaders, ensuring that extensive solicitation of tribal input is used to determine how programs are designed and implemented, including Block Grant programs. The Administration recognizes that Tribes are in the best position to understand the unique needs of their diverse communities, and tribes play a critical role in the budget and policy making process. As shown in the attached table, HHS provides funding to Tribes through 39 formula/block, either directly or indirectly through state pass through funds. Other HHS programs, such as Head Start, include similar statutory provisions but are not included on this table because they are not formula grants. For additional information on tribal eligibility for HHS grants, please visit www.hhs.gov/iea/tribal.

Cole 14- Lobbying

In the past year, what steps has HHS and each OpDiv taken to prevent and measure the effectiveness of its steps to ensure no federal funds are used to support lobbying activities prohibited by law?

Response

The Department is committed to ensuring the proper use of federal funds and compliance with all applicable restrictions on lobbying, and has in place long-standing Department-wide guidance to grantees, which has always prohibited lobbying at both the federal and state level. The Department has upheld this prohibition for years.

In April 2012, HHS revised the Department-wide guidance to reflect differences between the lobbying restriction provision in the FY 2012 Appropriations act and the analogous provision in prior years' acts. This updated guidance was provided to grantees. The Department takes these requirements very seriously.

Additionally, in line with a July 2014 Office of Inspector General report, the Assistant Secretary for Financial Resources (ASFR) facilitated increased information sharing across the Department about methods to identify the use of grant funds for legally prohibited lobbying activities, as well as centralized relevant guidance on its website.

In May 2015, ASFR provided a presentation to the Executive Committee on Grants Administration Policy, with details on the statutory and regulatory restrictions on lobbying. The presentation served as an opportunity to share guidance with the grants workforce regarding methods to identify the use of grant funds for legally prohibited lobbying activities. Shortly thereafter, ASFR posted a technical guidance document on the HHS Grants website, providing guidance to HHS's stakeholders and grantees. In addition, in December 2015, HHS issued guidance on lobbying in the revised Grants Policy Administration Manual (GPAM), an internal policy document that outlines HHS's policies on the administration of grants and cooperative agreements. The revised GPAM provides the HHS grants workforce with policy on the prohibition of the use of HHS grants funds for lobbying, and outlines the administrative requirements related to HHS's grants award recipients.

Cole 15- Management Controls Oversight

What actions have been taken over the past year by each OpDiv and HHS to improve oversight of management controls of federal funds to ensure federal funds support only the stated purposes authorized by law.

Response:

HHS maintains effective internal controls of federal funds and financial management systems to meet the objectives of the Federal Managers' Financial Integrity Act of 1982 (FMFIA) and the Office of Management and Budget (OMB) Circular A-123, Management's Responsibility for Internal Control. These objectives include ensuring reliable financial reporting; effective and efficient operations; and compliance with laws and regulations.

Department activities to support oversight and management of federal funds include providing guidance to Department operating components and assuring compliance with the objectives of FMFIA through completion of annual assurance statements required by OMB Circular A-123.

Additionally, the Department's governance and oversight of federal funds includes supporting the Assistant Secretary for Financial Resources who functions as the Chief Financial Officer for the Department, maintaining a robust Program Integrity Council, and oversight and implementation of the Federal Information Technology Acquisition Reform Act and the Digital Accountability and Transparency Act.

Cole 16- Title 42

Please update all the tables and dates provide in the fiscal year 2013 HHS Secretary hearing questions for the record for the questions under the title "Continued Excessive Use of Special Title 42 Pay Authority." The update should add a column for fiscal year 2013, FY 2014, FY 2015 actuals and projected for FY 2016 and FY 2017.

Response: This information is being compiled and will be provided under separate cover.

Cole 17- Recovery Audit Contractor (RAC) Program

- a. Please provide an updated timeline and specific steps CMS and OMHA are jointly taking to implement a process across all operations to increase its focus on preventing improper payments and paying claims right the first time. Specifically, how is CMS engaging the stakeholders to evaluate the program, identify challenges and make reforms. Finally, provide a report on how HHS established a systematic feedback process with the OMHA, CMS programs, and the RACs to prevent the appearance that RACs are selecting determinations to increase their fees and how effectiveness is measured?
- b. Please provide a table for each of the past five years with the number of improper claims identified through any program that were appealed at any level in the process (to include the lengthen of time prior to being assigned to an ALJ or adjudicator), the overturn rate at each step, and the value of the overturned rate. Please provide a separate breakout for all improper payments identified through the RAC process with the same criteria as above for each of the past five years.

Response:

- a. One of CMS' tools to reduce the Medicare improper payment rate is provider education and outreach, which gives Medicare FFS providers the timely and accurate information they need to bill correctly the first time. As you know, a primary driver of the Medicare improper payment rate is insufficient documentation to support payments for the services billed. The other causes of improper payments may be classified as medical necessity errors or administrative or process errors made by another party, such as incorrect coding errors. CMS is undergoing a number of corrective actions to address these errors, including innovative educational products to support provider education and outreach, new data analysis tools for contractors, expanding prior authorization to additional items and services, and the use of provider enrollment moratoria, among others. Each of these administrative actions are focused on paying claims right the first time, and if a claim is denied, addressing the denial at the earliest possible time in the Medicare appeals process.

In addition, CMS has announced a number of enhancements to the Recovery Audit Program in response to industry feedback. For example, CMS changed the Recovery Auditor "look-back period" for hospital patient status reviews to 6 months from the date of service in cases where a hospital submits the claim within 3 months of the date that it provides the service. This will apply to claims from providers referred by the Quality Improvement Organizations (QIOs). CMS also revised the limits on additional documentation requests (ADRs). ADR limits are established based on a provider's compliance with Medicare payment rules, are diversified across all claim types a facility may bill (e.g., inpatient, outpatient), and are incrementally applied for providers that are new to Recovery Auditor reviews to ensure that new providers are able to respond to requests timely and with current staffing levels. CMS also established a requirement that Recovery Auditors must complete complex reviews within 30 days, and failure to do so will result in the loss of the Recovery Auditor's contingency fee, even if an error is found. CMS further required Recovery Auditors to wait 30 days before sending a claim to the MAC for adjustment. This 30-day period allows the provider to submit a discussion period request before the MAC makes any payment adjustments.

These and other program improvements to reduce provider burden, enhance oversight and review accuracy, and increase program transparency can be found here:
<https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/Recovery-Audit-Program-Enhancements11-6-15-Update-.pdf>.

- b. HHS is committed to continuous improvement in the Medicare appeals process by implementing initiatives to enhance the quality and timeliness of service. The growth in the appeals workload has been exponential. For example, from FY 2009 to FY 2014, Level 3 (the Office of Medicare Hearings and Appeals) experienced an overall 1,222% increase in the number of appeals received annually, with the most dramatic growth in appeals workload occurring in the three-year period from FY 2011 through FY 2013. During these three years alone, workload grew by an unprecedented 545% (60,000 appeals in FY 2011 and 384,000 appeals in FY 2013). Level 4 (the Departmental Appeals Board) has also experienced significant growth in workload.

In the June 5, 2015 Report to Congress on Medicare Appeals, HHS noted although the growth of Recovery Auditor appeals has contributed to the increasing workload other types of workload are also contributing to growth in appeals, and subsequently the backlog, in significant ways. The increase in the workload has resulted from growth in each of the three workloads that HHS measures – Recovery Auditor, traditional workload (Medicare Part A and B; Durable Medical Equipment), and dual eligible workload, also known as the Medicaid State Agency workload. Further, with administrative actions undertaken by the Department to address the backlog, the current appeals in the backlog that were generated by Recovery Audit activities represent only a small fraction of the backlog.

We look forward to providing the Committee with additional data metrics for all four levels of the Medicare appeals process within HHS in the near future.

Cole 18- HHS Communication Expenditures

Please provide a table the displays how much each HHS Office of the Secretary Office and each OpDiv spent on communication and public relations related activities for each year from FY 2014 through FY 2017 estimate (by OpDiv and year). Further, please explain how each HHS and each OpDiv measures the effectiveness of its activities and what steps were taken in the past year or planned for FY 2016 and FY 2017 to reduce the overall cost and further improve effectiveness.

Response: This information is being compiled and will be provided under separate cover.

Cole 19- Medicare Competitive Bidding Program: Diabetes Test Strips

Congressional intent for this program was to preserve beneficiary access to the full range of products they were using, prior to the program's start. What criteria is CMS using to measure whether or not patients do in fact have access to the same range of diabetes test strip products that were available prior to the competitive bidding program?

Response:

The Durable Medicare Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) competitive bidding program is an essential tool to help Medicare set appropriate payment rates for DMEPOS items by replacing the existing, outdated, excessive fee schedule amounts with market-based prices. The program has resulted in reducing beneficiary out-of-pocket costs, providing significant savings to the Medicare program and taxpayers, and reducing over-utilization and fraud. Additionally the program has ensured continued beneficiary access to high quality items and services without compromising beneficiary health and safety.

CMS has closely monitored the results of the competitive bidding program since implementation in 2011 to ensure that beneficiary access to appropriate supplies and equipment has not been compromised. We take seriously any beneficiary access or health outcomes concerns, and that is the primary reason CMS has implemented a robust monitoring program to track and resolve any issues that might occur with DMEPOS competitive bidding program implementation. To the extent an issue arises, CMS will act promptly to address it.

The real-time claims monitoring system pays particular attention to potential changes in key indicators such as hospital admissions, emergency room visits, physician visits, and admissions to skilled nursing facilities before and after the implementation of the program. In addition, CMS has been carefully monitoring complaints coming into its regional offices, its toll-free number 1-800-Medicare, and to the Medicare Competitive Acquisition Ombudsman's office.

The health outcomes monitoring is one leg of a broad program oversight strategy implemented by CMS. This strategy also includes complaints tracking and resolution, and supplier oversight through accreditation, quality standards, competitive bidding program contracting and secret shopping. As a matter of standard practice, CMS uses this group of tools to identify, investigate and resolve any issues identified.

Cole 20- Hospital Preparedness/Public Health Emergency Preparedness Programs

There are two distinct programs under two separate offices that provide preparedness and response funding to states and select localities -- the Hospital Preparedness Program (HPP) funded through the Public Health and Social Services Emergency Fund and administered by the Assistant Secretary for Preparedness and Response, and the Public Health Emergency Preparedness Program administered by the Centers for Disease Control. In recent years, this funding has been governed by a single combined cooperative agreement that incorporates HPP requirements developed by ASPR and PHEP requirements developed by CDC. Funding provided in FY17 would support the first year of the next five year cooperative agreement.

- a. What is the advantage of having these programs combined into a single cooperative agreement when the constituent requirements are still developed by the two different agencies?
- b. Can you point to a meaningful reduction in administrative burden or improved coordination between public health departments and community health care and other providers under this structure?
- c. Would it be more efficient and effective to move the program funding into a single agency that would have lead responsibility for developing program requirements? If so, should that be ASPR or CDC?
- d. In recent years, as a result of the last program authorization, the HPP has shifted to funding coalitions of community providers instead of providing resources through the states to individual providers. What are the advantages of this approach – does it really incentivize meaningful coordination and collaboration, or is it simply diluting scarce budget resources among numerous participants?
- e. In the last cooperative agreement, the requirements regarding the Health Alert Network were substantially altered. In particular, the funding agreement no longer required that grantees adhere to the Public Health Information Network (PHIN) standards. Why was the requirement to adhere to these CDC standards eliminated? Will it be re-instated in the next five year cooperative agreement?
- f. In numerous post-incident reviews after major disasters (such as Superstorm Sandy and other recent hurricanes), the breakdown in the ability to track evacuated patients has been repeatedly cited as a serious problem. Please describe what thought is being given to the next cooperative agreement including a condition that at least major providers – such as large hospitals or nursing homes – use a meaningful electronic patient tracking?
- g. Are there any plans to build on the existing Hospital Available Beds in Emergencies and Disasters (HAvBED) standard in the next cooperative agreement? Does it include consideration of conditions to report more granular information with better defining of the “timeliness” of reporting to reduce variation in available data—please discuss the pros and cons of such potential conditions to improve interoperable reporting and operational success?
- h. Please describe how HHS, through the HPP/PHEP programs monitors the accessibility of dialysis centers during major disasters?

Response:

- a. ASPR administers the HPP and program funding supports building sustainable community health care coalitions that collaborate on emergency planning and, during disasters share resources and partner to meet the health and medical needs of their community. PHEP is administered by CDC, and program funding is used to advance public health preparedness and response capabilities at the state and local level.

The biggest advantage of a single cooperative agreement for HPP and PHEP is for the awardee. With a joint funding opportunity announcement (FOA), awardees submit materials to ASPR and CDC jointly. ASPR and CDC share application and reporting platforms, maximizing the efficiency to drive both health care and public health capabilities in an aligned and consistent format.

While some programmatic requirements are developed separately, a majority are developed and managed jointly by ASPR and CDC. For instance, the continuation guidance for the upcoming budget period includes 21 joint requirements that apply to both HPP and PHEP awardees. In addition, there are seven HPP-specific requirements and ten PHEP-specific requirements. HPP-PHEP cooperative agreement requirements are based on aligned preparedness capabilities (health care preparedness capabilities for HPP and public health preparedness capabilities for PHEP). ASPR and CDC preparedness capabilities have complementary content that describes how each discipline – public health and healthcare systems – contributes expertise to each capability, promoting safer, more resilient communities.

HPP-PHEP grant alignment is not a consolidation of the two programs. HPP and PHEP work plans and budgets remain separate to ensure accountability for the statutory requirements of each funding stream. In addition, the authorizing legislation for the two programs defines specific preparedness goals for each of the programs, which helps define joint, HPP-specific, and PHEP-specific program requirements.

- b. Since 2012, ASPR and CDC have reduced awardee administrative burden through:

- One HPP-PHEP funding opportunity announcement (FOA), funding application, and grant award
- Aligned HPP and PHEP grant cycles and reporting requirements
- One grants management organization
- Aligned capabilities model and program framework
- Joint metrics for aligned capabilities
- Joint technical assistance planning and site visits

In addition, during reviews of the HPP-PHEP funding application process, 70 percent of awardees agreed there has been significant reduction of awardee burden and a majority of awardees reported that HHS is “leading the programs in the right direction.”

This improved public health and health care system coordination was evident during the 2014-2015 Ebola response when ASPR and CDC worked successfully with state, local, and territorial public health officials and health care executives and leadership to coordinate Ebola preparedness and response activities, including designating and implementing a tiered health care system approach that supported the development of more than 600 Ebola assessment hospitals, 55 Ebola treatment centers, and nine regional Ebola and other special pathogen treatment centers.

While these programs have found efficiencies through coordination, each program serves a distinct purpose, and has proven valuable as two separate programs.

- c. In 2012, ASPR and CDC initiated grant alignment between the HPP and PHEP cooperative agreements recognizing that while the health care and public health sectors are unique, their close coordination will achieve improved health outcomes in the event of disaster. It is important to note that HPP and PHEP have very different goals despite having the same awardees. HPP targets preparedness and response of the health care system in order to assure medical care is provided to individuals impacted by a disaster. HPP funding supports the development and operation of regional health care coalitions, which incentivize diverse and often competitive private health care organizations (e.g., hospitals, EMS providers, long term care facilities) with differing priorities and objectives to work together. PHEP targets public health, population level interventions and works directly to prepare state, local, and territorial health departments to respond to emergency events.

The HPP-PHEP alignment effort focuses on reducing awardee burden by merging the two cooperative agreement programs into a single funding opportunity, as well improved federal efficiency and the state of national health care and public health preparedness. Due to the different focus of the HPP and PHEP programs, it is important that the two programs are managed by separate offices within HHS so that health care preparedness and response and public health preparedness and response capabilities align, but remain unique.

- d. From the beginning of the HPP program to today, HPP has provided funding, through cooperative agreement to 62 state, local, and territorial awardees (the public health departments in all 50 states, the District of Columbia, Chicago, Los Angeles County, New York City, and all U.S. territories and freely associated states). Recognizing that emergencies do not just impact individual hospitals alone, since 2012 HPP shifted its focus from individual facility-based equipment and supply purchases to a health care preparedness capability-based approach, which targets the development and operationalization of health care coalitions (HCCs). An HCC is a group of health care and public health organizations that work together to leverage resources and address challenges in health care delivery brought on by public health emergencies and disasters. During emergencies, these regional efforts help each patient receive the right care at the right place at the right time, ultimately saving lives.

HCCs incentivize diverse and often competitive health care organizations with differing priorities and objectives to work together. As of June 2014 (the most recent data available), there were approximately 24,000 health care facilities and other community partners participating in 496 HCCs nationwide. This is an increase in HCC membership of 47 percent

since June 2013, which demonstrates the value of a collaborative approach to health care emergency preparedness and response. Close to 5,300 hospitals participate in HCCs – roughly 83 percent of all U.S. hospitals. HCCs collaborate to ensure that each member has the necessary medical equipment and supplies, real-time information, communication systems, and trained health care personnel to respond to an emergency. HCCs include a variety of health care and public health organizations: hospitals, EMS, long-term care facilities, dialysis centers, behavioral health entities, public health departments, and emergency management. Each stakeholder facility/agency must optimize medical surge capacity and resilience planning in order to maximize the potential of the local health care system as a whole to accommodate disasters. Thus, the HPP cooperative agreement must provide for accountability at both facility/agency level as well as system level performance.

The diverse membership of HCCs also contributes to their success in preparing a community to respond to a wide variety of incidents that impact the public's health. Medical evaluation and treatment of incident victims require coordinated activities that extend beyond hands-on medical care. By building and sustaining HCCs, information can be collected, analyzed, and managed to support rapid patient distribution to appropriate facilities, patient tracking, family support, information coordination, and resource and transportation management. HCCs also disseminate knowledge of the range of injury and illness to inform response and timely requests for additional resources. The coordination processes and health care capabilities promoted by HPP's coalitions are designed to limit community morbidity and mortality after exposure to a hazard.

Past investments in HCCs have proven beneficial. Successes include responses to: the Amtrak train derailment in 2015; preparations for the papal visit to several U.S. jurisdictions in 2015; the Louisville, Mississippi tornado in April 2014 that wiped out the Winston Medical Center; the Oso, Washington mudslides in March 2014; and many other public health and medical events, including responses to severe weather events and infectious disease outbreaks, that have impacted communities across the nation. In each of these cases, HCCs worked together to share information and resources to meet the needs of the community.

- e. Public Health Information Network standards remain available for use. However, states have found PHIN requirements difficult to implement. In preparation for the 2011 PHEP grant period, CDC developed fifteen public health preparedness capabilities to assist state and local health departments with preparedness planning. To develop these capabilities, CDC consulted with its own subject matter experts and others from across the federal government and the state and local practice community. The capabilities, which include an information sharing capability, describe the functions or critical elements that need to occur to achieve the capability, as well as the associated tasks and resource elements. Resource elements include planning, skills and training, and equipment and technology. Applicable PHIN standards were incorporated as recommended by the subject matter experts. As CDC develops the 2017-2022 HPP-PHEP cooperative agreement, it is working with subject matter experts to craft requirements that further develop and sustain health alerting and notification systems that meet the goals of CDC's national surveillance strategy.

- f. Within the funding provided through the HPP cooperative agreement, awardees must strive to build and maintain prepared health care systems, advance the development and maturation of health care coalitions, strengthen regional coordination, and ensure the health care system can maintain operations and surge to provide acute medical care during all-hazards emergencies. That said, the current HPP appropriation is insufficient to provide funding to individual health care facilities to implement electronic patient tracking. As such, mandating that health care facilities who participate in regional health care coalitions (HCCs) have such systems is not recommended at this time.

As part of the HPP-specific requirements in the cooperative agreement funding opportunity, HPP awardees must ensure the HCCs in their jurisdictions actively engage public health, EMS, hospitals, and emergency management in preparedness activities. In particular, EMS providers should be integrated into planning for tracking emergency patients and to prevent critical deficits in transport capabilities during hospital evacuations, casualty redistribution between health care facilities, and initial transport capabilities and patient care from incident scenes to health care facilities. EMS is an integral partner in patient tracking. HPP awardees should familiarize themselves with the following data standards: the National Emergency Medical Services Information System (NEMSIS) data standard, the Tracking of Emergency Patients data standard, and the Hospital Availability Exchange (HAVE) data standard.

Further, when a state requests federal support to move patients, the Department of Health and Human Services (HHS), as the lead federal agency, will implement the patient movement system, which is comprised of five functions: (1) patient evacuation (to include patient reception and management), (2) medical regulating, (3) en route medical care, (4) patient tracking that is integrated with tracking of general population evacuees, and (5) re-entry.

The Joint Patient Assessment and Tracking System (JPATS) is a “Web App” that is part of the National Disaster Medical System (NDMS) Disaster Medical Information Suite (DMIS) that is designed to track every patient moved by the federal government from start to finish.

State and local health departments are encouraged to consider using JPATS for their patient tracking application needs. HHS offers JPATS to state and local health departments without any licensing fee, though there are software and hardware cost considerations. Entities can use JPATS for their own isolated incidents, for state-to-state responses and for larger events when the federal government responds.

- g. The ASPR Hospital Available Beds in Emergency Disasters (HAVBED) team is in the process of upgrading both technical and programmatic elements contained within the current system to modernize reporting processes, improve visibility of bed data, and enhance visualizations. Technical updates include improved site aesthetics, advanced web services, and the provision of state-to-state data sharing directly on the site. Programmatic upgrades include the addition of new bed types, bed sub-types, and streamlining facility reporting. By increasing the number of bed and bed sub-types available for reporting, we hope to improve visibility of beds that are not currently being reported because they do not fall within our existing eight bed categories. By including both acute and non-acute care health care facilities in our system, we hope to gain a more accurate picture of health care system needs across the spectrum, not just those limited

to hospitals. Other programmatic changes include aligning bed reporting exercises with NDMS bi-monthly bed drills. All of these changes will be available for implementation by awardees in the next cooperative agreement.

During the planning phases of the upgrade, considerations were made to improve visibility of data and to improve timeliness in reporting. The inclusion of additional bed types and bed sub-types provides more granular bed availability data within hospitals. The difficulty in creating these sub-types is that all states/territories do not have the same existing bed categories within their own jurisdictions (for example, some awardees may associate intermediate care/step-down beds with medical surgical units and others may associate them with intensive care units). Similar challenges exist in streamlining facility types. Efforts to improve timeliness in bed reporting are consistently met by challenges in the ability of awardees to maintain technical staffing and funding for HAvBED, in light of competing programmatic priorities. In consideration of future needs, the team is contemplating proposing the collection of individual level bed data as opposed to aggregated data to meet the needs of all bed reporting platforms within ASPR.

- h. Through ASPR's HPP, HHS monitors and advances access to required dialysis services, through close coordination and collaboration with the Center for Medicare & Medicaid Services (CMS) and its Kidney Community Emergency Response (KCER) contractors, throughout the entire disaster cycle (preparedness, response, recovery, and mitigation). This is a multi-tiered process involving close coordination at local, regional, state, and federal levels.

One key preparedness initiative that HPP and KCER have promoted together is the participation of dialysis centers within regional HCCs so the needs and requirements of dialysis centers during emergencies and disasters can be quickly identified, addressed, and ultimately remedied so access to dialysis services can be maintained. HPP's Field Project Officers continually educate state health officials and emergency managers about the impact equipment, power, and water supply failures have on dialysis centers ability to continue services so back-up generators can be quickly installed and patients relocated to other dialysis centers for required treatments. Moreover, HPP continually promotes the need for providing early dialysis in advance of a storm or disaster and the need to implement renal diets, by sharing a wide array of resources and information about the dialysis community through ASPR's Technical Resources Assistance Center & Information Exchange (TRACIE).

During response and recovery activities, HPP helps facilitate direct communication between regional dialysis networks and their respective state health official, while also promoting CMS and KCER and the HHS Secretary's Operations Center to identify any unmet needs or bottlenecks gaps impacting dialysis centers and their patients to help promote continued access to dialysis services. Moreover, the recently launched HHS emPOWER Map (www.phe.gov/empowermap) is an interactive publicly available map that provides zip code-level information about the number of Medicare beneficiaries who rely on electricity-dependent medical equipment, such as home dialysis machines. In the event of an emergency, HHS and CMS can use a secure mechanism to provide health departments with the names and addresses of individuals who use such equipment.

We have made strides in forging a strong working relationship between HPP and the dialysis community, at both operational and strategic levels. HPP will continue to have a representative on KCER's advisory board and working group to further strengthen these ties and safeguard dialysis patient's needs, including access to required services, during emergencies and major disasters.

Cole 21- Pandemic Flu and Preparedness

- a. Please describe how the FY 2017 budget ensure the nation is ready to handle another outbreak like H1N1 or a bio hazard threat despite dramatic decreases in pan flu preparedness budgets or project bioshield? What steps is HHS taking in FY 2016 and planned in FY 2017 to reduce the risk of such events given the reductions to these two programs? Specifically how what is HHS doing to improve HHS' pandemic influenza preparedness programs?
- b. Please describe how our preparedness against pandemic influenza changed in the past year to justify the FY 2017 request level? What steps is HHS taking to ensure HHS sustains readiness efforts against this threat?

Response:

- a. Project BioShield (PBS) is a shared national defense priority. The FY 2017 President's Budget will enable us to make meaningful progress on vital medical countermeasure procurements. Unlike a grant or research program that supports a steady and recurring level of effort, the Project BioShield budget is made up of a different set of discrete procurements in any given year when medical countermeasures are mature enough in development to meet FDA requirements for accessibility under Emergency Use Authorization. In FY 2017, the new resources will enable the Department to procure small quantities of a few additional chemical, biological, radiological and nuclear medical countermeasures sufficiently mature for procurement, including:
 - New Ebola vaccines and immunotherapeutics for the prevention and treatment of Ebola infections;
 - New high-throughput biodosimetry devices to measure internal radiation exposure following a detonation;
 - New antibiotics for the treatment of bacterial biothreats and high priority antimicrobial resistant bacteria;
 - New diagnostics for the detection of anthrax in exposed persons; and
 - Replenishment of anti-neutropenia cytokines for the treatment of radiation-induced blood illnesses.

ASPR and the PHEMCE are committed to maintaining our national preparedness and making sure that medical countermeasures are available when needed. Maintaining stockpiles of medical countermeasures typically entails large procurement costs and is associated with substantial carrying costs. In an era of constrained resources, BARDA and its PHEMCE partners are mindful of the need to meet established requirements, sustain preparedness, and be good stewards of the taxpayers' investments. To this end, the PHEMCE is currently working to refresh the Material Threat Assessments that form the foundation for our requirements, many of which have not been reassessed in years. ASPR, for its part, emphasizes innovative approaches to total lifecycle cost-containment and strives to decrease the long-term costs of stockpiling medical countermeasures.

- One method is repurposing of commercial products and taking advantage of its commercial market, under vendor managed inventory (VMI). This method is currently

being leveraged for cytokines to address neutropenia resulting from exposure to ionizing radiation.

- Another method that ASPR is employing is stockpiling of bulk intermediates. Bulk products do not have expiry associated with them like final drug products and can be maintained for longer periods of time. Stockpiling of bulk intermediates also allows ASPR to cut manufacturing times if additional product is necessary for a larger event.

Having supported the development of the first licensed cell-based and recombinant influenza vaccines in the United States, BARDA's influenza program has initiated efforts to broaden the spectrum and increase the effectiveness of influenza vaccines with the ultimate goal of developing a "universal" flu vaccine that protects against most or all circulating influenza A viruses and whose efficacy persists over many flu seasons. BARDA has also initiated a program to support the development of antiviral immunotherapeutics, which may demonstrate greater efficacy and a wider window for administration than the current generation of neuraminidase inhibitors. BARDA continues to support the advanced development of novel small-molecule antiviral therapies and of new, rapid, point-of-care diagnostics, which it is hoped will facilitate more targeted use of antiviral therapy. Finally, BARDA has collaborated with NIH, FDA, and CDC through the Flu Risk Management Meeting (FRMM) process to identify steps the government can take to mitigate the risk of the late emergence of seasonal influenza viruses that are poorly matched to existing vaccine strains. Planning is under way to establish an interagency Seasonal Influenza Vaccine Initiative that will implement actions identified by the FRMM to reduce such risks. BARDA continues to enhance its annual pandemic influenza appropriation by leveraging no-year funds from prior pandemic influenza supplemental appropriations.

- b. BARDA enhances the nation's pandemic preparedness through its vaccine stockpiling contracts as well as the development of new influenza therapeutics (including monoclonal antibodies) and rapid diagnostic tests. BARDA has shifted its programmatic emphasis in recent years from the expansion of vaccine manufacturing capacity towards development of new and more sustainable countermeasures and to the development of products, such as a "universal" flu vaccine, that will provide enhanced pandemic preparedness by reducing population susceptibility through regular seasonal vaccination programs. Until such a vaccine can be developed, BARDA will replenish expired vaccine inventories as needed to maintain a high level of pandemic preparedness

A substantial share of the National Pre-Pandemic Influenza Vaccine Stockpile (NPIVS) was purchased with supplemental funds appropriated for the H5N1 and 2009-H1N1 responses. All of the vaccine in the NPIVS has been continuously monitored to ensure the preservation of its potency, but some of the vaccine in the stockpile has now been stored for up to 10 years. BARDA has undertaken the BARDA Readiness In Times of Emergency (BRITE) study to evaluate the safety and immunogenicity of product that has been in long-term storage. This clinical trial opened on March 15 and has already enrolled nearly 400 subjects. The results will address the question of viability and inform plans for using the NPIVS.

Cole 22- Health Resources and Services Administration

- a. Report language directed the Health Resources and Services Administration (HRSA) and the Substance Abuse and Mental Health Services Administration to ensure funding is distributed relatively equally among participating health professions. Could you describe HRSA's efforts in fiscal year 2016 to ensure equity among the health professions who receive grant funding?
- b. The President's Budget proposes to transfer the Behavioral Health Workforce Education and Training Program to HRSA. Can you give us more detail about how HRSA plans to leverage existing capacity in health workforce development and build capacity specifically in behavioral health as part of this transfer? Can you share with us your plans for the fiscal year 2017 grant cycle; specifically do you anticipate any changes to the funding announcement?
- c. Could you provide us an update on the progress of HRSA's efforts to test intervention strategies related to perinatal transmission of Hepatitis B?

Response:

- a. In FY 2014 SAMHSA and HRSA collaborated to launch the Behavioral Health Workforce Education and Training Program to expand the mental health and substance abuse workforce serving children, adolescents and transition-age youth at risk for developing, or who have developed, a recognized behavioral health disorder. HRSA and SAMHSA are committed to ensuring the funding awards support the appropriate distribution among participating health professionals, including paraprofessionals in FY 2016. HRSA and SAMHSA are considering options related to the Behavioral Health Workforce Education and Training (BHWET) program to address this distribution, and we will provide an update as soon as possible.
- b. While HRSA and SAMHSA will continue to work collaboratively to administer this program, HHS proposes to move the program to HRSA to allow HHS to streamline the administration and oversight functions within a single agency.

HRSA, with SAMHSA, is in the process of developing plans for the proposed FY 2017 BHWET program. As the current BHWET grantees' project periods end in FY 2017, HRSA plans to hold a new national competition that better addresses health professions as well as current/emerging behavioral health workforce challenges. Additional information will be shared with the Sub-committee as it becomes available.

- c. HRSA is supporting, through a National Training and Technical Assistance Cooperative Agreement, the development of a comprehensive Perinatal Hepatitis B Toolkit that will focus on screening practices, linkage to care, and perinatal care and management. This resource is expected to feature such items as a provider checklist, needs assessment screening tool for providers and health educators, fact sheets containing best practices, and sample screening protocol models focused on perinatal hepatitis B in health centers. This effort is drawing on the expertise of the CDC's viral hepatitis program and incorporates perinatal hepatitis B resources such as the CDC Screening Pregnant Women for Hepatitis B Virus (HBV) Infection, and the CDC Screening and Referral Algorithm for HBV Infection among Pregnant Women. The toolkit is being developed in conjunction with health centers that provide care to

a large proportion of foreign born patients who are at high risk for Hepatitis B and is slated for delivery in the summer of 2016.

Additionally, HRSA is in discussions with partners to determine the most effective methods for implementing the toolkit in health centers nationwide to help reduce and eliminate transmission of perinatal hepatitis B.

Cole 23- Administration for Children and Families

- a. In regards to the implementation of the reauthorized Child Care and Development Block Grant, it is my understanding that the Administration for Children and Families has been working with states, territories, and Tribes to ensure that the program balances promoting self-sufficiency of families, improving quality of care, and ensuring healthy development and school readiness of children. Through your work with states, can you please provide more detailed information on the resources needed to ensure effective implementation of the law in a way that will help states build on their commitment to improving childcare quality?

Response:

We appreciate Congress' bipartisan work to reauthorize the Child Care and Development Fund. In December 2015, HHS proposed revisions to the program regulations to reflect the changes contained in the Child Care and Development Block Grant Act of 2014 (CCDBG). The Notice of Proposed Rulemaking's regulatory impact analysis estimated the average annual cost of full implementation at \$1.1 billion. Of this total, only \$5 million in costs stem from areas where HHS interpreted the statute and proposed clarifications through regulation. As you know, the child care program is supported by a combination of federal and state dollars, with, on average, 60% of the funds coming from appropriations for the two federal child care programs (CCDBG and Child Care Entitlement). The Department is committed to supporting states through technical assistance and additional resources as they implement the law's requirements. To better meet the needs of states and to assist effective implementation efforts, the President's FY 2017 Budget requests \$2.962 billion in discretionary funding for CCDBG, an increase of over \$200 million from the FY 2016 enacted levels.

Cole 23- Administration for Children and Families

- b. In a report released by the U.S. Department of Education in April 2015, it was noted that children from low-income families are less likely to be enrolled in preschool than their peers – 41 percent compared to 61 percent. As part of the recent bipartisan Every Student Succeeds Act, Congress demonstrated its commitment to addressing this lack of equity by authorizing the Preschool Development Grants program that builds off an initiative that was first funded in Fiscal Year 2014 to support high-quality preschool opportunities. As funding in Fiscal Year 2017 will shift from the Department of Education to Department of Health and Human Services, can you provide more information on how the departments will work together to jointly administer the program? How will the proposed \$100 million increase for the Preschool Development Grants program in Fiscal Year 2017 be used better coordinate and expand early learning services for children and families, with a goal of supporting state efforts to expand access to high quality preschool?

Response:

The Department of Health and Human Services and Department of Education will continue to jointly administer the Preschool Development Grants program in 2017 and beyond. HHS has worked closely with our counterparts at the Department of Education to ensure that our programs are coordinated, serve our nation's children as best as possible, and create a continuum of high-quality early learning services beginning at birth and continuing through age 5.

The Departments have had success in the joint administration of Race to the Top-Early Learning Challenge and Preschool Development Grants in previous years and engage in numerous other activities to ensure coordination at all levels. For example, the Departments co-chair an Interagency Policy Board on Early Learning that coordinates policy, programs, research, and technical assistance across agencies and issues joint policy statements on key issues, including the inclusion of young children with disabilities in classrooms and programs with typically developing peers and preventing and eliminating the expulsion of young children from early childhood programs. Other examples of collaboration include the joint development of Birth-to-Five: Watch Me Thrive, which provides a toolkit to increase rates of developmental screening and follow-up, and dissemination of materials highlighting how to utilize Medicaid to support creating school environments with physical and mental health supports.

We appreciate the importance of close coordination in the joint administration of the Preschool Development Grants (PDG) program, and will continue to keep your staff updated as we proceed with planning and implementation.

As you state, the President's FY 2017 Budget requested an increase of \$100 million for PDG. The increase in Preschool Development Grants is necessary to expand upon the efforts already underway in the 18 States that make up the first cohort of grantees. The additional funding would enable HHS and ED to fund new grants under the reauthorized Elementary and Secondary Education Act (ESEA) program in addition to supporting the final year of

continuation grants for the first cohort. The new grants will improve the overall quality of preschool programs while improving coordination across early learning systems and increasing parent choice and knowledge about these programs. Ultimately, if all children are to have access to high-quality preschool programs, states must be supported. These activities will support and enhance many of the activities required under the reauthorized Child Care and Development Block Grant.

Cole 23- Administration for Children and Families

- c. Madam Secretary, the Administration for Children and Families has been committed to supporting initiatives that promote healthy child development and school readiness through family engagement, increased access to high quality early learning opportunities, and the building of caring communities. To continue progress made by low-income children during their early years, there is a need to focus attention on best practices to help students transition into the elementary school classroom. Can you please highlight some best practices in this area? How can resources be directed to help children not only improve their school readiness, but actually have the supports they need as they make the transition?

Response:

HHS works with the Department of Education (ED) to support and sustain high-quality programs and create more consistency of practice for children from birth up through age 8. Together, we've worked on making the experience of children in high quality, comprehensive programs like Head Start continue as they enter elementary school. HHS has produced resources for families, early childhood programs, and kindergarten teachers which are free and available on our Early Childhood Learning and Knowledge Center website including a brief—*PLANNING FOR THE TRANSITION TO KINDERGARTEN: Why it Matters and How to Promote Success* (<https://eclkc.ohs.acf.hhs.gov/hslc/tta-system/teaching/docs/transition-brief.pdf>). On the website, there are also training videos and activity calendars for teachers and parents.

The Departments co-chair an Interagency Policy Board on Early Learning, that coordinates policy, programs, research, and technical assistance across agencies and issues joint policy statements on key issues. Some of our most successful efforts recently have included joint policy statements from HHS and ED that emphasize consistent best practices for early childhood programs and K-12 schools. We have issued joint policy statements on preventing and eliminating preschool suspension and expulsion in early childhood programs, as part of a larger initiative to look at disparities in suspension and expulsion across all ages. We have also issued a joint policy statement about the inclusion of children with disabilities in classrooms with typically developing children throughout their education careers. We are in the process of incorporating public comments on a position statement on family engagement through the early childhood period, which will be issued later this year. We appreciate your leadership on this important issue.

Cole 23- Administration for Children and Families

- d. Could you give us an update on the current arrivals of unaccompanied children for fiscal year 2016 compared to the past 3 fiscal years? Please include the number of temporary beds, occupancy rate, and status of permanent beds.

Response:

In FY 2016, the Office of Refugee Resettlement has expanded its capacity to shelter unaccompanied children through both standard shelters operated by grantees and through the identification of temporary shelter facilities on federal property, that can be activated as needed. Ensuring that ORR has sufficient flexibility to accommodate unanticipated increases in caseloads is prudent to ensure that the Border Patrol can continue its vital national security mission to prevent illegal migration, trafficking, and protect the borders of the United States.

As we have highlighted over the last few months, the Department of Homeland Security (DHS) saw an increase in the number of unaccompanied children (UC) and family units apprehended along the southwest border in the first quarter of FY 2016. In mid-December, referrals of UC to HHS decreased significantly. The entire administration has been closely monitoring trends and coordinating to ensure an effective response to any changes in migration flows.

The Office of Refugee Resettlement at HHS increased the capacity of current providers to from 7,900 to 8,500 beds in December and took steps to add temporary beds at two federal facilities – the Department of Labor JobCorps site in Homestead, FL and the Holloman Air Force Base near Alamogordo, NM. As of February 25, 2016, HHS had opened 250 temporary shelter beds at Holloman Air Force base. As of March 31st, 2016 all temporary beds at Holloman and Homestead are in reserve status, given that current caseloads do not necessitate their active use, but they could be brought back online if needed. The approximate number of UC in care is 4,600.

The number of referrals of unaccompanied children that ORR received from the Department of Homeland Security during the last three fiscal years are as follows:

FY 2015 – 33,726
 FY 2014 – 57,496
 FY 2013 – 24,668

During the first quarter of FY 2016, ORR received 17,075 referrals. This was an increase of 176% over the first quarter of FY 2015, an increase of 76% over the first quarter of FY 2014, and an increase of 315% over the first quarter of FY 2013. The number of referrals dropped significantly in January and February to levels well below 2014 referrals [Referrals for the first five months of FY 2016 (22,484) still significantly exceeding referrals for the first five months of any preceding year including FY 2014, underscoring the difficulty of projecting the number of UCs who will be apprehended and referred to HHS in any particular month or season and, thus, the challenge of shelter capacity planning..

Given these uncertainties, HHS has incorporated lessons learned from the summer of 2014, when caseloads increased quickly, and adjusted a number of its practices to more flexibly and efficiently respond to fluctuations in migration while also maintaining high standards of care for this vulnerable population.

Because of the large fluctuations in arrival numbers throughout the year, it is appropriate to have a mix of “standard” beds that are available year-round, and “temporary” beds that are brought online as needed in the event of increases in arrivals. Accordingly, HHS developed a bed capacity framework with grant and contract mechanisms that allow us to have a sufficient base number of standard beds, with the ability to quickly add temporary beds, which has improved ORR’s ability to accommodate changing flows. ORR will continue to update its bed capacity planning to account for the most recently available data, including information from interagency partners, to leverage available funds to be prepared for possible increases in caseloads.

The uncertainty of the number of UC who will be referred to HHS is not the only challenge in operating the program. The Budget presents another challenge, because funding is set at the beginning of the fiscal year when the funding need is highly uncertain. Without a mechanism that provides additional funding if UC referrals are higher than can be accommodated with the base appropriation, HHS is limited in its ability to respond to high referral levels and could face circumstances where it is unable to bring on the needed shelter capacity due to a lack of resources. It is important to note that the timeframe for bringing a temporary shelter into operation varies significantly depending on the location of the site, the amount of work needed to get facilities ready for children, and how long it takes to hire staff for the facility. Thus, if a significant increase in UC referrals occurs over a short amount of time, it is important that temporary shelter facilities are ready or near-ready for operations. However, if sufficient funds may not be available to support additional shelter facilities may not be available, it limits the extent to which HHS is able to ready such facilities ahead of time.

In short, the lack of reliable additional funding if referrals are higher than can be accommodated with base resources makes ensuring that adequate shelter capacity is available when it is needed that much more difficult and, depending on the number of UCs who are referred to HHS, could make it impossible.

For these reasons, the President’s FY 2017 Budget proposes a contingency fund for this program that would provide additional resources only if referrals exceeded what could be accommodated with existing resources; if enacted, the contingency fund would help ensure ORR had sufficient capacity to adjust to large and unpredictable fluctuations in need for shelter capacity. Despite operational improvements, without a contingency fund, our ability to respond to significant increases in migration is compromised.

Cole 23- Administration for Children and Families

- c. Could you describe the health screening process and health care services provided to unaccompanied children after they enter the United States? In addition, could you provide information on the types of medical conditions that would prohibit entry into the United States and those medical conditions, which if present, still permit entry? If available, could you provide summary statistics related to the health screening information?

Response:

The safety of the children that the Office of Refugee Resettlement (ORR) cares for, and the safety of the American public, are top priorities for the Unaccompanied Children Program. The Centers for Disease Control and Prevention (CDC) believes that the children arriving at U.S. borders pose little risk of spreading infectious diseases to the general public.³ ORR has procedures in place to mitigate even those minimal risks.

Each unaccompanied child referred to ORR must receive an initial general medical examination within 48 business hours of admission at a care provider facility. The purposes of the initial examination is to assess general health of the child, to administer complete immunizations in keeping with U.S. standards, to find out about health conditions that require further attention, and to detect contagious diseases, such as influenza or tuberculosis. Care providers are responsible for ensuring that healthcare providers examining and treating the children are following ORR's latest medical guidance and reporting the findings to ORR. Countries in Central America, where most of the unaccompanied children are from (Guatemala, El Salvador, and Honduras), have childhood vaccination programs, and most children have received some or all of their recommended childhood vaccines. As a precaution, if a child's vaccinations are not up-to-date based on vaccination records or a vaccination record is not located, it is ORR's policy to provide the child with all CDC recommended vaccinations, including varicella, measles, mumps, rubella, meningococcal disease, and pertussis, per CDC guidelines. All of the children receive a tuberculosis test, and girls over age 10 receive a pregnancy test.

In addition to the initial medical examination, ORR facilitates and funds health care for all unaccompanied children in its custody with the goals of ensuring the children's physical and mental well-being as well as the safety of care providers, medical personnel and communities. Services include routine medical and dental care, family planning services, emergency health services, immunizations, administration of prescription medications, and appropriate mental health interventions.

In the event that there are positive test results, or a communicable disease manifests after a child is in ORR's custody, ORR follows established infectious disease protocols to prevent infection of others and to ensure the child receives and completes appropriate medical care and

³ CDC Factsheet on Unaccompanied Children: Health Information for Public Health Partners, available at <http://www.cdc.gov/usmexicohealth/pdf/unaccompanied-children-factsheet.pdf>.

treatment. ORR care providers report to local and state health departments following established legal and regulatory requirements. ORR follows CDC guidelines. ORR provides a monthly report to public health officials, which includes the latest information about selected infectious diseases⁴ diagnosed in unaccompanied children while in ORR care provider settings. During fiscal year FY 2015, active tuberculosis (TB) disease was diagnosed in 4 children (FY 2015 period prevalence: 12 per 100,000 persons). All diagnoses resulted from routine TB screening done upon admission to an ORR care provider program. All cases of TB meet the CDC definition for reporting. As of February 25, 2016, no children had been diagnosed with TB in FY 2016. During FY 2015, varicella was diagnosed in 85 children. To date, varicella has been diagnosed in 19 children in FY 2016 (October 1, 2015 to January 31, 2016). This count may change because of reporting delays.

⁴ These are the nationally notable diseases that are communicable by the airborne or fecal-oral routes and capable of causing outbreaks in congregate settings. Other emerging infectious diseases of national interest may also be included in this report.

Cole 23- Administration for Children and Families

- f. For the Unaccompanied Children program, what is the average cost of post-release follow-up services that are provided for 6 months for fiscal years 2015 and 2016?

Response:

In FY 2016, the average cost of post release services is \$2,806 per child per year. Under ORR's current policy, the length of time a child would receive post-release services can vary between six months and many years, depending on his or her individual needs. For instance, a child released with post-release services after a home study, as mandated by the Trafficking Victims Protection Reauthorization Act (TVPRA), would be eligible for services until they turn eighteen (e.g. a 12-year-old would receive post-release services for six years), or until the final disposition of the UC's immigration case.

Cole 23- Administration for Children and Families

- g. What would the cost be for the Office of Refugee Resettlement to provide one expedited home study and one follow-up visit for every child? How do home studies or post-release follow-up services monitor a child's well-being and prevent child exploitation? How do those services also help sponsors comply with the child's conditions of release?

Response:

In FY 2016, the average cost of a home study is approximately \$1,949. Additionally, the process of conducting a home study adds approximately two weeks onto a child's length of stay in an ORR facility. Assuming a child is cared for in a standard shelter, which costs approximately \$223 a day in FY 2016, each home study would add an additional shelter cost of approximately \$3,122. Taken together, the total estimated cost of a home study in FY 2016 is approximately \$5,071 per child. The cost of caring for children in temporary shelters is higher, typically \$500 per child per day in FY 2014 (the last time significant numbers of temporary beds were used) but some facilities were more expensive. Assuming a child is cared for in a temporary shelter with typical FY 2014 costs, the total estimated cost of a home study would increase to \$8,949 per child.

ORR is not able to estimate the cost of a single follow-up visit for a UC at this time. Typically post release services provided by ORR grantees include a combination of in person visits and telephonic case management and referrals. In FY 2016, the average cost of post release services per child is \$2,806 per year. Under ORR's current policy, the length of time a child would receive post-release services can vary between six months and many years depending on his or her individual needs. For instance, a child released with post-release services after a TVPRA mandatory home study would be eligible for services until they turn eighteen (e.g. a 12-year-old would receive post-release services for six years), or until the final disposition of the UC's immigration case.

Before placing a child with a sponsor, HHS goes through a multi-step assessment process with the goal of ensuring that a sponsorship will be safe and appropriate. Consistent with the TVPRA, ORR conducts home studies "before placing a child with an individual" in certain circumstances specified in the statute, such as if the child is a victim of a severe form of trafficking or the child has a disability.⁵ A home study is an in-depth investigation of the potential sponsor's ability to ensure the child's safety and well-being. The process is conducted prior to a child being released to a sponsor and includes fingerprint background checks of the sponsor and adult household members, home visit(s), and an in-person sponsor interview and possibly interviews with other household members. Though home studies are solely conducted prior to the release of a child to a sponsor, ORR does have authority to provide follow up services, which may include in person post release services and case management, as outlined below.

Although ORR's custody ends upon release, its commitment to providing resources, connecting children to services, and protecting vulnerable children from abuse or exploitation

⁵ 8 U.S.C. 1232(c)(3)(B).

does not end. ORR has authorities that permit it to provide a range of services and resources post-release, and it makes use of that authorization to establish policies and procedures that, among other things, are intended to protect those children that may be vulnerable to abuse or exploitation after they are released from our care.

ORR follows up with children and their sponsors 30 days after release and provides every child with a card with an ORR Help Line phone number to call with safety-related concerns. Care providers must conduct a Safety and Well Being Follow Up Call with an unaccompanied child and his or her sponsor 30 days after the release date. The purpose of the follow up call is to determine whether the child is still residing with the sponsor, is enrolled in or attending school, is aware of upcoming court dates, and is safe. The care provider must document the outcome of the follow up call in the child's case file, including if the care provider is unable to contact the sponsor or child after reasonable efforts have been exhausted. If the follow up call indicates that the sponsor and/or child would benefit from additional support or services, the care provider refers the sponsor or child to the ORR Help Line.

After a child has been released, the ORR Help Line provides unaccompanied children a resource for safety-related concerns and provides sponsors with a resource for assistance with family problems and child behavior issues, referrals to community providers, and assistance finding legal support and enrolling unaccompanied children in school.

ORR also provides post-release services to many children and sponsors. Post-release services are intended to help link the child and/or the sponsor with community services or other ongoing assistance. Post-release service providers coordinate referrals to supportive services in the community where the unaccompanied child resides and provide other child welfare services, as needed. ORR has expanded the categories of children who automatically receive post-release services over the last year to cover more of the most vulnerable children we serve. Currently, ORR offers post-release services to children who receive a home study; children released to a non-relative or distantly related sponsor; children whose placement has been disrupted or is at risk of disruption within 180 days of release where the child or sponsor has called the Help Line; and, on a case-by-case basis where it is determined the child has mental health or other needs. ORR is mindful of the need to continuously re-examine its policies and procedures, including in the area of post-release services.

Cole 23- Administration for Children and Families

- h. What is the average cost per bed in emergency shelters (Department of Defense facilities and others)? What is the cost per bed for temporary reception at existing Office of Refugee Resettlement placements? Are there ways for the program to expand temporary beds within their grantees or provide for fluctuations in custody placements that can offset the cost of emergency shelter costs at temporary camps or Department of Defense facilities?

Response:

For budget and planning purposes, HHS assumes an average daily cost of approximately \$223 for a standard shelter bed funded for a 12-month period. However, the cost of temporary shelter capacity is significantly higher and varies by site, because of the need to develop facilities quickly and hire a robust staff over a short period of time. In 2014, the cost of caring for children in temporary shelters was typically about \$500 per child per day but some facilities were more expensive than this due to facility or staffing requirements of that particular site.

Operating the Unaccompanied Children Program presents challenges because of uncertainties about how many children will arrive and when. Incorporating lessons learned from the summer of 2014, when caseloads increased quickly, HHS has adjusted a number of its practices to more flexibly and efficiently respond to fluctuations in migration while also maintaining high standards of care for this vulnerable population.

Because of the large fluctuations in arrival numbers throughout the year, it is appropriate to have a mix of “standard” beds that are available year-round, and “temporary” beds that are brought online as needed in the event of increases in arrivals. Accordingly, HHS developed a bed capacity framework with grant and contract mechanisms that allow us to have a sufficient base number of standard beds, with the ability to quickly add temporary beds, which has improved ORR’s ability to accommodate changing flows. ORR will continue to update its bed capacity planning to account for the most recently available data, including information from interagency partners, to leverage available funds to be prepared for possible increases in caseloads. Effective bed capacity planning must balance the need for rapid capacity expansion against the high cost of maintaining empty capacity. Given the large number of referrals in the first quarter of FY 2016, HHS has been working with current providers to bring on additional standard shelter space before turning on temporary beds.

The Office of Refugee Resettlement at HHS increased the capacity of current providers operating standard beds from 7,900 to 8,500 beds in December before taking steps to add temporary beds at two federal facilities – the Department of Labor JobCorps site in Homestead, FL and the Holloman Air Force Base near Alamogordo, NM. As of March 31, 2016, all temporary beds at Homestead and Holloman are in reserve status.

It is important to note that the cost of shelter capacity includes both the cost of the capacity when it is being utilized and the cost of maintaining the capacity when it is not being utilized but it is staffed and ready to care for children when needed. The length of time that it takes to stand up a temporary shelter varies significantly across grantees and facilities. If it will take 60

days to stand up a facility, then a decision to make that facility operational must be made two months before those beds are needed. Since migration flows are uncertain and highly variable, sometimes that means bringing on a facility and then paying to keep it open even if migration flows have changed and it is not immediately needed. Some capacity, by contrast, can be made operational more quickly and, thus, can be activated much closer to the time when the capacity will be needed, reducing the likelihood of paying for capacity that is not ultimately needed. In the first quarter of FY 2016, HHS utilized camp facilities in Texas in this manner. These facilities can be made operational very quickly – and can be shut down very quickly. Thus, HHS was able to open up capacity when it was needed and shut it down quickly when UC referrals fell. While the per-day cost of the temporary shelters was high, \$500 per child per day based on typical FY 2014 costs, HHS saved money by not paying for shelter capacity when it was not needed.

Unfortunately, most temporary shelter space cannot be activated in less than 30-60 days (and some facilities take longer) and also takes more time to shut down, raising the overall cost.

The uncertainty of the number of UC who will be referred to HHS is not the only challenge in operating the program. The Budget presents another challenge, because funding is set at the beginning of the fiscal year when the funding need is highly uncertain. The President's FY 2017 Budget proposes a contingency fund for this program that would provide additional resources only if referrals exceeded what could be accommodated with existing resources; if enacted, the contingency fund would help ensure ORR had sufficient capacity to adjust to large and unpredictable fluctuations in need for shelter capacity. Without a contingency fund, our ability to respond to significant increases in migration is compromised.

Cole 23- Administration for Children and Families

- i. What is the process for confirming the identity and eligibility of sponsors for unaccompanied children? What systems are checked to verify an individual's identity?

Response:

ORR takes very seriously its responsibility to place children in a safe and healthy environment following their release from its custody. A background check is conducted on all potential sponsors, and steps are taken to verify a potential sponsor's identity and relationship to the child. Over the last year, ORR has implemented additional measures to enhance the pre-release screening of potential sponsors and others who are likely to come into contact with children post-release.

In finding sponsors for children, the first preference is parents, followed by legal guardians, adult family members, and family friends recommended by the family. About 50 percent of sponsors are parents and approximately 30% close relatives. Currently, all sponsors must submit proof of identity, including a copy of a government-issued identification and a copy of his or her birth certificate. Sponsors must also submit proof of the unaccompanied child's identity, such as a copy of unaccompanied child's birth certificate as well as proof of relationship. If the unaccompanied child's family and/or sponsor indicate(s) that they do not have copies of the birth certificates available and will be unable to obtain them, then the Case Manager at the care provider facility, in collaboration with the parent and/or sponsor, is able to request the certificates from the consulate.

If a birth certificate or other verifiable evidence of identity is unavailable, the Case Manager, in consultation with the third party Case Coordinator, may recommend that the ORR staff approve a DNA test in some instances (e.g., infants and young children, unaccompanied children with cognitive delays).

Care providers and ORR verify the unaccompanied child's and/or potential sponsor's birth certificate with the Consulate when the authenticity of the birth certificate is questionable or the birth certificate provided may belong to someone other than UC or sponsor for whom they are presented.

ORR is working with Federal partner subject matter experts to identify and incorporate enhanced interview and document verification techniques into the sponsor assessment process. We will continue to evaluate our policies and procedures to determine whether additional steps can be taken to further protect the safety and well-being of these children.

Cole 23- Administration for Children and Families

- j. Could you describe the coordination efforts between the Department of Education and the Department of Health and Human Services on the Preschool Development Grants program?

Response:

The Department of Health and Human Services and Department of Education will continue to jointly administer the Preschool Development Grants program (PDG) in 2017 and beyond. HHS has worked closely with our counterparts at the Department of Education to ensure that our programs are coordinated, serve our nation's children as best as possible, and create a continuum of high-quality early learning services beginning at birth and continuing through age 5.

Consistent with the statute, the purposes of the PDG program are to coordinate early childhood education programs in a mixed delivery system of providers, including schools, licensed child care centers, Head Start, or other community-based organizations, that will prepare low-income and disadvantaged children to enter kindergarten and to improve the participation of children in high-quality programs in this system. These goals are consistent with our efforts to align all early learning programs and ensure a continuum of services for children from birth to school entry. Although we are early in the process, we are working collaboratively with the Department of Education to ensure that the purposes as defined in the statute are clearly articulated and promote coordination beyond the initial planning year through the lifetime of the grant. Additionally, we are working to ensure that we remove any barriers for states to implement and provide services through a mixed-delivery system and, through better alignment of policies and regulations, across departments and funding sources.

We appreciate the importance of close coordination in the joint administration of the PDG program, and will continue to keep your staff updated as we proceed with planning and implementation.

Cole 24 (on behalf of Rep. Pearce): Senate HSGA Report: Advanced Premium Tax Credits to non-citizens

Sen. Johnson of Wisconsin, the chairman of the Senate Homeland Security and Government Affairs committee, recently released a report highlighting the fact that approximately \$750 million in Advanced Premium Tax Credits were inappropriately awarded to those who were unable to prove their citizenship. Additionally, the committee found that IRS and HHS failed to coordinate and develop a plan to recoup improper cost assistance payments.

The IRS only developed a plan to recover these funds after Sen. Johnson's inquiry into HHS' improper payments, and there exists major doubt that the majority of those improper payments will ever be recouped. Ultimately, the report highlights a lack of accountability, and efficiency in both IRS and HHS.

- a. How can this misuse of hundreds of millions of taxpayer dollars possibly be justified?
- b. How does HHS and IRS plan to work together in the coming year to address and close this costly loophole?
- c. Will one or both agencies be ultimately responsible for recovering improper payments?
- d. Of those who received excess or improper payments, how many of those were likely illegal immigrants, and how many were citizens who did not provide sufficient evidence of citizenship?
- e. What resources have you dedicated from your budget request to address these corrective actions?

Response:

We have a robust verification process to make sure that those who are eligible for financial assistance can receive it, while also protecting taxpayer dollars. All Marketplace applicants have their citizenship or immigration status verified through the SSA or DHS and must attest to this information under penalty of perjury. If there is an inconsistency between the consumer's application and what is in the SSA or DHS databases, then the consumer must submit documentation to address this data matching issue. The Marketplace must, by law, provide the applicant with time to provide documentary evidence or otherwise resolve the data matching issue. Many applicants in fact successfully resolve the data inconsistency by submitting satisfactory documentation within the required time. If the Marketplace is unable to verify the citizenship or lawful presence of an individual, their coverage (and any relating financial assistance) is terminated. As a result of that process, we ended coverage for approximately 500,000 consumers in 2015 who failed to produce sufficient documentation on their citizenship or immigration status.

However, having eligibility ended or adjusted is not a conclusion about an individual's citizenship or immigration status or the truth of an attestation – only that a Marketplace did not receive sufficient documentation in the inconsistency period prescribed by law. It is possible that an individual whose coverage was terminated or adjusted for lack of sufficient

documentation does in fact have the requisite citizenship or immigration status entitling them to coverage and financial assistance through the Marketplace.

Cole 25 (on behalf of Rep. Pearce)- Office of Refugee Resettlement Transparency

On February 24, 2016 the Department of Health and Human Services (HHS) announced the temporary housing facility at Holloman Air Force Base (HAFB) would officially be moved into reserve status. Since January, HHS has utilized Department of Defense (DOD) approved available space for the temporary housing of unaccompanied children (UC). All children are expected to be moved out of the facility by February 26, 2016, and relocated to permanent HHS facilities or reunited with sponsors within the U.S. Despite the transfer of UCs out of HAFB, several long-standing questions regarding HHS's management of this facility remain.

- a. What was the total cost-to-date for the UC program at HAFB?
- b. What was the price per child per day at the facility? Included in this answer, please provide the cost breakdown for this cost.
- c. What percent of that daily cost was allocated to contract employees?
- d. It is my understanding that the number of UCs never reached the total 250 capacity. Was the government paying as if all beds were occupied?
- e. What is the cost-per-day for executing reserve status?
- f. How many employees (contract and agency) are retained during reserve status? What is the highest salary? What is the lowest?
- g. How much was paid for security in the January 25 – February 26 timeframe?
- h. What is the cost of security at the facility while in reserve status? How much are hired security guards paid per person per hour? How much is paid per person in overtime?
- i. How much will it cost to return to operating status from reserve status, should that be the case later in 2016?
- j. How is Holloman Air Force Base reimbursed while HHS executes the UC program? And once in reserve status? Is rent paid to the base for the duration of their stay? Is rent paid prior to use or once the program is complete? Are incidentals paid to the base as well?
- k. What was the cost of altering the facility for use by HHS?
- l. What is the potential cost of upkeep at the facility while in reserve status?
- m. What was the cost of health care provided on campus? What was the cost of health care provided off campus (including emergency care)? What was the cost of health care (per child) provided at the permanent facility prior to their arrival at Holloman Air Force Base?

Response:

- a. Currently, we are working with our contractors to receive final invoices for the initial startup costs for the facilities and the estimate for the funding required to keep the facilities in reserve status, ready to activate again within 30 days' notice. Since we do not know if or when the facilities will need to become operational again, and we don't know how many children may use them, it is difficult to predict final costs.

The average daily cost to provide shelter to a child in a permanent HHS shelter is approximately \$223 per day, but the cost of temporary shelter capacity is significantly higher, because of the need to develop facilities quickly and hire significant qualified staff in a short period of time.

In 2014, the cost of caring for children in temporary shelters was typically about \$500 per child per day but some facilities were more expensive than this due to facility or staffing requirements of that particular site.

HHS is committed to ensuring that all unaccompanied children referred to our custody are cared for appropriately. To do so, we make every effort to ensure funds are used as effectively as possible to provide safe shelter and adequate services and that costs are contained to the degree possible.

Simpson 1- IHS Facilities

Like Mr. Cole, I too sit on the Interior & Environment subcommittee, with oversight of the Indian Health Service budget, and I too am concerned about the crisis in the Great Plains. Having been out to Pine Ridge and Rosebud, I understand how recruitment and retention are a real challenge.

I also understand that U.S. Public Health Service Commissioned Corps Officers have been deployed to the Great Plains to help these hospitals get back on their feet, and I'm grateful for your leadership on that. I'm wondering, though, if there's an opportunity to use more Corps Officers at IHS facilities proactively, rather than reactively.

I notice on your website that, of the 2,890 Commissioned Corps active duty stations, three-quarters of them are not IHS facilities.

I notice, for example, that a medical officer is currently assigned to the National Park Service in Lakewood, Colorado. IHS needs quality medical officers in the Great Plains.

Furthermore, the National Indian Health Board says that in 2014, several Corps Officers were pulled out of IHS facilities and sent to West Africa to respond to the Ebola epidemic. Now, I'm not saying that Ebola wasn't important, but was pulling our people out of a health crisis here, to deal with a crisis overseas, really our best option? I also understand that Zika funding, like Ebola in 2014, is important this budget cycle, but we must also prioritize our obligations to Indian country and the crisis they face with retaining much need providers and care givers.

Can more be done with the Commissioned Corps to help the Indian Health Service?

Response:

U.S. Public Health Service (PHS) Commissioned Corps officers are currently assigned to 22 different agencies or departments. Of the 6,588 PHS officers on active duty, 1,937 (30%) are assigned to the Indian Health Service (IHS), primarily providing primary clinical care, engineering and environmental health services, or serving in leadership positions at headquarters or in the Area Offices. The Food and Drug Administration (FDA) has the next largest number of officers, at 1102, with the Centers for Disease Control and Prevention (CDC) having 926 officers.

The IHS and Great Plains Area (GPA) leadership are committed to providing the highest quality health care and ensuring that medical providers have the required clinical skills and credentials to provide services in outpatient, urgent care, and Emergency Department settings. The Commissioned Corps has been a valuable resource, and offers a robust source of available candidates in certain categories; however, in other categories, the pool of qualified candidates is limited. A small percentage of current Corps medical officers not already assigned to the IHS have the current clinical competencies and credentials to immediately assume a clinical role in an urgent care or emergency department setting. Conversely, in the Nurse category, where 31% of nurses are assigned to the IHS, over 30% of the remaining PHS officers provide clinical care as part of their regular daily duties. The IHS has successfully utilized the Corps to temporarily fill nursing positions in Great Plains Area critical sites via deployments. We are also working with the Commissioned Corps to funnel applicants to a critical

Great Plains Area IHS site. The efforts may be expanded to other critical sites throughout the IHS. The IHS and other federal agencies that hire PHS officers would benefit from additional authorized incentives to assist with the recruitment and retention of qualified medical and dental officers, and to compete with the VA and the private sector. Specifically, the IHS is seeking the discretionary use of the hiring authorities under chapter 74 of title 38 of the US Code that are primarily available to the Department of Veterans Affairs to recruit and retain its health care personnel. IHS proposes to make the title 38, chapter 74 hiring authorities available to government employees who serve in health care positions, providing direct patient-care services or services incident to direct patient-care services. This authority would allow competitive annual leave accrual for these employees and the hiring of qualified non-citizen health care providers.

Simpson 2- HRSA Chief Dental Officer

Several agencies have the position of a Chief Dental Officer, such as the NIH, CDC, and IHS. With over \$50 million for HRSA dental programs, does HRSA have a Chief Dental Officer to oversee these programs and ensure the funding is being appropriately utilized?

- a. Could you describe the role and current position within the HRSA organization of the head dental official? Is there an official "Chief Dental Officer"? We have heard reports, HRSA has a Special Dental Advisor opposed to a Chief Dental Officer. Could you describe the authority the Special Dental Advisor has over HRSA dental programs? Can they direct policy and resources?
- b. In 2008, this committee directed HRSA to establish a Chief Dental Officer position. The position was to be on a par with the Chief Dental Officers in other agencies. The HRSA dental programs are vital for improving the delivery of health care to underserved areas as well as educate a sufficient national dental workforce. What steps is HRSA taking to ensure the HRSA Chief Dental Officer has the authority to direct policy over the oral health programs?

Response:

- a. HRSA recently elevated its oral health activities by placing responsibility for coordinating oral health activities in the Office of Planning, Analysis, and Evaluation within the Office of the Administrator, assuring better integration and leadership across the agency. The Senior Dental Advisor position encompasses the same responsibilities and duties of the Chief Dental Officer. HRSA's Senior Dental Advisor is responsible for coordinating oral health activities across all HRSA programs, and advising program officials throughout HRSA on the recruitment, assignment, deployment, retention, and career development of dentists and other oral health professionals within the agency. The Special Dental Advisor works closely with program and budget officials on policy and resources pertaining to oral health
- b. The HRSA Senior Dental Advisor is responsible for coordinating oral health activities across all HRSA programs and advising program officials throughout HRSA on the recruitment, assignment, deployment, retention, and career development of dentists and other oral health professionals within the agency.

Simpson 3- World Health Organization

On January 15, 2016, the World Health Organization (WHO) issued draft “Guidance on Ending the Inappropriate Promotion of Foods for Infants and Young Children.” The guidance proposes to establish significant new restrictions and prohibitions on the promotion and marketing of milk products (including follow-up formulas, milk, cheese and yogurt) for young children up to three years of age without providing any evidence, scientific substantiation or an impact analysis to justify the measures.

We continue to hear that milk and milk products are good for our health. The HHS Dietary Guidelines notes a healthy eating pattern includes...fat-free or low free-free dairy, including milk, yogurt, cheese, and/or fortified soy beverages. The HHS guidelines apply to individuals age 2 and older. The WHO appears to contradict the nutrition's food provided to children under three in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

- a. Does HHS support these WHO draft guidelines? If so, why?
- b. What is HHS’s role in influencing WHO in this process?
- c. How can we work together to ensure the WHO is developing science-based guidance to prevent unintended negative health consequences for young children and potentially violate World Trade Organization (WTO) trade rules, including imposing restrictions on the use of intellectual property by brand owners?

Response:

At the request of Member States, the World Health Organization (WHO) developed draft guidance on ending the inappropriate promotion of foods for infants and young children.⁶

The WHO developed this guidance using a Scientific and Technical Advisory Group process. Convened in 2013, the Scientific and Technical Advisory Group produced several reports, including a draft of the guidance that they presented to WHO in 2015. Following online and in-person public consultations, the WHO presented revised draft guidance to Member States at the WHO Executive Board meeting in January 2016. Following the meeting, the WHO opened an additional consultation period in February 2016 to allow time for further Member State comment. The guidance is not binding on Member States.

The WHO draft guidance advises Member States on ending inappropriate promotion to consumers of foods for infants and young children. The draft does not seek to prohibit the marketing of all milk products consumed by young children, to limit product availability, or to revise recommendations for optimal infant and child feeding practices. The document does recommend that countries prohibit the promotion of breast-milk substitutes marketed for feeding children up to three years of age.

⁶ As presented in report EB138/8: Maternal, infant and young child nutrition. Available at http://apps.who.int/gb/ebwha/pdf_files/EB138/B138_8-en.pdf (Accessed March 14, 2016).

As the agency representing the United States to WHO governing bodies, HHS submits feedback to WHO and represents U.S. policy perspectives. HHS is working with other relevant federal agencies to prepare a technical comment submission to WHO, and has had multiple conversations with stakeholders on the matter. HHS has not taken a position on the draft guidance on inappropriate promotion, pending clarifications from WHO following the February consultation period. HHS supports the effort to make evidence-based recommendations on public health, including child nutrition, and will continue to work with the other agencies and discuss remaining concerns with stakeholders.

Simpson 4- Medicare Advantage

Obamacare contained a provision that capped Medicare Advantage funding for counties. That included the bonuses for exceptional plans.

As part of the Affordable Care Act, new payment methodology was imposed that included a cap on county-by-county benchmarks in Medicare Advantage. While a technical change, the impact is fairly dramatic: in many counties across the country, and in my District, high quality plans are being penalized putting Medicare Advantage enrollees at risk. In Idaho alone, this means a loss of \$6.9 million affecting 88,000 seniors in my state. I understand there could be an administrative solution to this problem.

- a. Is there a way you can work administratively to correct this problem?
- b. Can the subcommittee provide help?

Response:

- a. We share your concern about any rate-setting mechanism that diminishes incentives for MA plans to continuously improve the care provided to Medicare beneficiaries. However, we do not believe we have the discretion under section 1853(n)(4) of the Social Security Act to eliminate application of the pre-ACA rate cap or exclude the bonus payment from the cap calculation. The bonus payment is based on an increase to the “applicable percentage” which is a component of the benchmark calculation itself.
- b. The Budget includes a proposal to reform Medicare Advantage payments to improve the efficiency and achieve sustainability of the program for all Medicare beneficiaries. This proposal has four components that better incentivize Medicare Advantage plans to submit cost-effective bids while preserving beneficiary supplemental benefits and enhancing quality incentives. As part of the balanced and comprehensive approach, the proposal would standardize quality bonus payments across counties by removing the doubling of the quality bonus payment which is only available in certain areas and lifting the cap on benchmarks for plans that are entitled to receive a quality bonus payment. I look forward to working with the subcommittee to enact reforms to Medicare Advantage payments.

Rogers 1- Lung Cancer Screening

In December of 2013 the U.S. Preventative Task Force recommended annual screening for lung cancer with low-dose computed tomography (LDCT) in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Because of this recommendation insurance companies must cover the screening and Medicare has agreed to coverage for at risk seniors.

- a. How does HHS through CMS, CDC, insurance companies, and state licensing bodies work to educate providers on new medical procedures, techniques, and screening procedures of this nature to expedite the adoption of this new information across the practice of medicine?
- b. What is the average time for new techniques of this nature to be adopted and what is being done to expiate the timeframe, in both rural and urban areas?
- c. Finally, specifically on the LDCT procedures how are CMS and private insurance companies working to encourage this screening?

Response:

- a. CDC has engaged in research, surveillance and program support activities to increase awareness and improve clinical practice in this area. For example, CDC:
 - Published “Policies and Practices for Cancer Prevention: Lung Cancer Screening Programs” which describes how grantees of CDC’s National Comprehensive Cancer Control Program can increase awareness about lung cancer screening among people who are at high risk. Plans are underway to further disseminate materials through webinars and papers.
<http://www.cdc.gov/cancer/ncccp/pdf/lungcancerscreeningprograms.pdf>
 - Published a comprehensive overview of the scientific literature regarding lung cancer screening in a leading journal for primary care providers. The article, “Lung Cancer Screening with Low-Dose Computed Tomography for Primary Care Providers” is freely available to everyone on the internet and CDC’s website. <http://www.sciencedirect.com/science/article/pii/S0095454314000116>
 - Funded investigators under CDC’s Prevention Research Center program to study barriers to incorporating smoking cessation into lung cancer screening programs and to develop practical and efficient approaches for monitoring the quality and performance of lung cancer screening. These research studies will fill important information gaps and support the implementation of high-quality lung cancer screening programs.
 - Added questions about lung cancer screening among adults to the National Health Interview Survey in 2010 and 2015. As a result, this national survey will provide surveillance data on recent trends in the receipt of lung cancer screening in the United States.

Additionally, through the National Cancer Policy Forum, CDC is working with the National Academy of Medicine (NAM) to plan a Workshop on Implementation of Lung Cancer Screening, to be held in June 2016. The planning committee has representation from CDC, the National Cancer Institute, the American Cancer Society, academic institutions, and other partners. A summary of the workshop will be available from the NAM about six months after the workshop.

In regard to Medicare, CMS issued a National Coverage Determination (NCD) on *Screening for Lung Cancer with Low Dose Computed Tomography* in February 2015⁷ and CMS-affiliated authors published a related article.⁸ CMS also disseminates information to providers on Medicare's preventive benefits through its Medicare Learning Network (MLN), and the Medicare Administrative Contractors (MACs) are responsible for on-going communication with providers in their respective regions. In addition, CMS conducts regularly scheduled "Open Door Forum" teleconferences with physicians, hospitals, skilled nursing facilities, rural health clinics and other providers, to present updates and answer questions on Medicare coverage and payment developments. Other educational materials, directed at both beneficiaries and providers, include the annual "Medicare & You" handbook (particularly highlighting Medicare-covered preventive services), brochures on benefit-specific topics, and a wide range of on-line materials.

With respect to private insurance, non-grandfathered health insurance issuers and group health plans are required to provide benefits for and may not charge cost sharing with respect to evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved. The USPSTF assigned a "B" rating to this recommendation in December 2013. Our regulations require that plans and issuers cover such services beginning one year after the recommendation is issued. Plans and issuers were required to begin covering this service in December 2014. We note that state Departments of Insurance have primary enforcement responsibility for ensuring issuer compliance with this provision.

- b. It is difficult to estimate the timeframe for adoption of a new screening test, as implementation of some tests may be more complex than others, and there are multiple issues that must be addressed to implement an effective lung cancer screening program.
- c. Following USPSTF recommendations, annual screening for lung cancer with low dose computed tomography (LDCT) is considered a preventive service for adults 55-80 who have a history of smoking, and therefore, under the Affordable Care Act, is available under most health plans with no cost sharing. Details regarding this preventive service can be found on <https://www.healthcare.gov/preventive-care-adults/>. Additionally, CMS has issued a National Coverage Determination stating that the evidence is sufficient to add a lung cancer screening, counseling, and shared decision making visit, and for appropriate beneficiaries, annual screening for lung cancer with LDCT, as an additional preventive service benefit under the

⁷ <https://www.cms.gov/medicare-coverage-database/details/nca-decision-memo.aspx?NCAId=274>

⁸ See Screening for Lung Cancer with Low-Dose CT – Translating Science into Medicare Coverage Policy” in the May 28, 2015 *New England Journal of Medicine* (available at <http://www.nejm.org/doi/full/10.1056/NEJMmp1502598>).

Medicare program as long as the beneficiary, radiologist and the facility meet certain criteria. These criteria are detailed in a decision memo on the CMS website and can be found at the following link: <https://www.cms.gov/Medicare/Medicare-General-Information/MedicareApprovedFacilities/Lung-Cancer-Screening-Registries.html>

Rogers 2

The Federal Office of Rural Health Policy (FORHP), within the Health Resources and Services Administration (HRSA), currently funds eight rural health research centers (RHRC) and three rural Health policy analysis initiatives. On January 14, 2016, FORHP requested applications for 7 centers to be funded annually over a four-year period.

- 1. RHRC's have an incredibly important mission – providing HRSA and federal health policy makers with information and analysis on rural health matters ranging from telehealth to mental health policy. The Centers produce policy-relevant research that informs FORHP's policy team on critical issues.**

- a. **Has ORHP pre-selected focus areas? If so, please provide for the Committee.**

Response: Thank you for your support of our mission. The Federal Office of Rural Health Policy (FORHP) requires that each Rural Health Research Center (RHRC) adopt at least one research focus area for its four-year funding period, and that it be selected from topics FORHP considers to be policy-relevant and of enduring importance to rural America.

The most recent Funding Opportunity Announcement, for FY 2016 funding,⁹ provides the following instructions for selecting focus areas (from p. 8) and identifies policy areas of importance to FORHP:

“Propose at least one area of concentration that the RHRC will focus on throughout the 4-year award cycle and briefly explain how the chosen topic(s) aligns with FORHP’s charge as specified in Section 711 of the Social Security Act, as well as other emerging and historic health policy issues. Applicants may propose to focus their work around one area of concentration for the entire RHRC, or they may propose to include multiple areas of concentration that draw on the varied expertise of their key personnel. The topic(s) of concentration must be policy-relevant and of enduring interest and importance to rural providers, rural stakeholders and/or the health of rural communities. FORHP is particularly interested in areas of concentration that capture hospital payment and policy, primary care payment and policy, post-acute care, quality, workforce (including training and retention programs such as rural training tracks), health information technology, Medicare (including Medicare Advantage) and Medicaid, pharmacy and prescription drug policy, insurance provisions, ambulance and emergency medical services (EMS) policy, mental and behavioral health, health disparities, and ongoing activities related to the transition from volume to value”

- b. **Recently, the Obama Administration acknowledged the unique health and economic challenges in Appalachia – an area of high disability rates, prescription drug misuse and abuse, and cancer prevalence. Further, Appalachia is impeded by unique telecommunications and state jurisdictional challenges impeding telemedicine, health treatment – particularly mental health – and overall healthcare delivery, affordability, and accessibility. Is the current RHRC proposal review process affording opportunity to consider these unique health challenges within the rural healthcare discussion?**

⁹ *Rural Health Research Center Cooperative Agreement*, Announcement Type: New, Competing Continuation, Funding Opportunity Number: HRSA-16-054, Catalog of Federal Domestic Assistance (CFDA) No. 93.155.

Response: Yes, the review process for selecting the seven new RHRCs considers the unique health challenges posed by Appalachia and other rural areas, where socio-economic challenges may hinder access to quality medical care and health outcomes.

As indicated in response to Question 1a. above, we request that RHRCs propose topic(s) of concentration that are “policy-relevant and of enduring interest and importance to rural providers, rural stakeholders, and/or the health of rural communities.” Health information technology, mental and behavioral health, and health disparities are among suggested areas of concentration.

Importantly, we grant funding via cooperative agreement, a grant mechanism that allows FORHP staff and awarded research centers to jointly identify potential research topics. Thus, both FORHP staff and individual awardees can suggest a research focus on certain areas, markets, or regions.

As you know, supporting rural America is a priority for me as Secretary, and a priority for HRSA. At the FORHP specifically, our team focuses on these issues through a number of varied functions, including with the National Advisory Committee on Rural Health and Human Services, discussions with others in the Department, and the White House Rural Council.

- c. **Related, rural areas, notably Appalachia, rely on rural health networks to strengthen access and reduce costs. Has FORHP considered an analysis of the effectiveness of these networks, assessed data, and provided recommendations to bolster network performance?**

Response: FORHP recognizes that network structures can be helpful in addressing rural community challenges, such as workforce shortages. Rural health networks are expected to play important roles in the Administration’s delivery system reform initiative and in various current and anticipated demonstrations and payment programs administered by CMS.

To analyze and assess the effectiveness of these networks, the FORHP-funded Rural Telehealth Research Center is examining the impact of telehealth networks funded through FORHP’s Evidence-Based Tele-Emergency Network Grant Program on health outcomes. This partnership between two FORHP grant programs will support a multi-site analysis of the provision of tele-emergency services. FORHP anticipates additional related RHRC research.

To bolster network performance, FORHP is currently funding research on its Rural Health Network Development Planning Grant Program. This effort will use literature review and dialogue with expert informants to identify key challenges to rural health network development. This research will then assess the extent to which FORHP’s Rural Health Network Planning grantees from 2006 to 2008 transitioned to successful networks. FORHP is also funding the development of a Rural Health Network evaluation toolkit, to serve as an evidence-based resource for communities to build rural health networks.

Finally, FORHP plans to fund the Rural Health Network Development Program later this calendar year. The purpose of this program will be to support mature, integrated rural health care networks that have combined the functions of its network participants to address the healthcare needs of the targeted

rural community and simultaneously positioned themselves for healthcare delivery system reform by tracking outcome measures tied to care delivery, information, and incentives.

Harris 1- Biosecurity Threats, medical countermeasures

- a. The HHS medical countermeasure enterprise was originally built to prepare for deliberate chemical, biological, radiological and nuclear (CBRN) threats. Today we are also facing new threats from emerging infectious diseases, like Ebola and Zika, and tomorrow it may be a new disease. The people, partnerships, companies and platforms built up for a bioweapons attack are now being called upon to respond to all hazards - pandemic flu and emerging infectious disease – and yet resources in your base Fiscal Year 2017 Budget Request are significantly reduced. On the one hand you are requesting a \$1.9 billion emergency supplemental to combat the Zika virus, while on the other your Fiscal Year 2017 Budget Request reduces funding for key programs in this enterprise like the BioShield Special Reserve Fund. Do you believe we should pass an emergency supplemental each time an emerging infectious disease poses a global health threat?

Response:

Several members have raised the idea that we consider more sustainable funding approaches to public health threats, and we agree with that approach. Medical countermeasure (MCM) preparedness can only be achieved by sustained investment in capabilities and products. Emergency supplemental appropriations also are often needed to ensure that preparedness can be achieved, as we saw with Ebola.

To address its core mission of developing MCMs against chemical, biological, radiological, and nuclear threats (CBRN) and pandemic influenza, the Biomedical Advanced Research and Development Authority (BARDA) within the Office of the Assistant Secretary for Preparedness and Response (ASPR) has honed its processes and procedures, supported the development of critical product development support services and infrastructure, and assembled a world-class workforce expert in all aspects of product development. Analogous to the way that well-oiled day-to-day health care system practices allow communities to respond effectively to terrorist attacks or other mass casualty events, these product development capabilities have allowed BARDA to pivot to address emerging threats when a rapid response is required.

It has proven much more challenging to develop a pipeline of products against foreseeable emerging infectious disease (EID) threats. To a certain extent, this reflects the lack of international consensus about which agents should be prioritized, but it also reflects the lack of dedicated funding for EID threats as a category.

Emergency supplemental appropriations have been necessary in order to provide emergency funding to expedite development of MCMs and to appropriately address the larger, public health crisis. For emerging and infectious diseases, almost all of the development projects (vaccines, therapeutics, and diagnostics) are in the very early stages of development. There is often no commercial market for EID MCMs until there is an outbreak. Therefore, projects will remain in early development until there is an outbreak and industry sees a potential market for the specific MCMs. Project BioShield is intended for procurement of very advanced MCMs. The vaccines, therapeutics, and diagnostics to address Ebola and Zika were in very early stages of development and would not qualify for procurement under Project BioShield thus the focus on advanced development through BARDA. BARDA has been

leaning forward based on lessons learned from our responses to pandemic influenza and Ebola; investing in innovative platform technologies that may be able to address future emerging infectious diseases while still having utility to progress development of MCMs for CBRN and pandemic influenza threats. Investing in platform technologies will assist in rapidly developing vaccines, therapeutics, and diagnostics without having to start from scratch because the technologies have been previously proven or evaluated.

Harris 1- Biosecurity Threats, medical countermeasures

- b. In the five year budget regarding the public health emergency medical countermeasure enterprise ("PHEMCE multiyear budget") you provided the Appropriations committee last year, HHS outlines nearly \$870 million in procurements. Yet your Fiscal Year 2017 Budget Request for the BioShield Special Reserve Fund is only \$350 million, a reduction in nearly \$500 million, and a \$160 million reduction from last year. How can you justify reducing funding for BARDA and the BioShield Special Reserve Fund when just last year you told us BARDA needed nearly double that amount?

Response:

The report on Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) estimates for spending in FY 2015 – FY 2019 are based on professional judgment for these programs. The report describes the importance of programs that address specified threats identified through the Material Threat Determination process used to set strategic requirements for medical products. Projected estimates are based on specific assumptions to maintain current preparedness efforts and projections are made without consideration of other competing priorities that are reflected in the formulation of the President's Budget.

Project BioShield is a shared national security priority. The FY 2017 President's Budget will enable us to make meaningful progress on vital MCMs procurements. Unlike a grant or research program that supports a steady and recurring level of effort, the Project BioShield budget is made up of a different set of discrete procurements in any given year when MCMs are mature enough in development to meet Food and Drug Administration (FDA) requirements for accessibility under Emergency Use Authorization. In FY 2017, the new resources will enable the Department to procure small quantities of a few additional chemical, biological, radiological and nuclear medical countermeasures sufficiently mature for procurement, including:

- New Ebola vaccines and immunotherapeutics for the prevention and treatment of Ebola infections.
- New high throughput biodosimetry devices to measure internal radiation exposure following a detonation.
- New antibiotics for the treatment of bacterial biothreats and high priority antimicrobial resistant bacteria.
- New diagnostics for the detection of anthrax in exposed persons.
- Replenishment of anti-neutropenia cytokines for the treatment of radiation-induced blood illnesses.

ASPR and the PHEMCE are committed to maintaining our national preparedness and making sure that MCMs are available when needed. Maintaining stockpiles of MCMs typically entails large procurement costs and is associated with substantial carrying costs. In an era of constrained resources, BARDA within ASPR and its PHEMCE partners are mindful of the need to meet established requirements, sustain preparedness, and be good stewards of the taxpayers' investments. To this end, the PHEMCE is currently working to refresh the material threat assessments that form the foundation for our requirements, many of which have not been reassessed in years. ASPR, for its part,

emphasizes innovative approaches to total lifecycle cost-containment and strives to decrease the long-term costs of stockpiling MCMs.

- One method is repurposing of commercial products and taking advantage of their commercial market, under vendor managed inventory (VMI). This method is currently being leveraged for cytokines to address neutropenia resulting from exposure to ionizing radiation.
- Another method that BARDA is employing is stockpiling of bulk intermediates. Bulk products do not have expiry associated with them like final drug products and can be maintained for longer periods of time. Stockpiling of bulk intermediates also allows ASPR to cut manufacturing times if additional product is necessary for a larger event.

Harris 1- Biosecurity Threats, medical countermeasures

- c. Over the last fifteen years, HHS has created, refined and tested its response to known biological and emerging threats. This started with anthrax in 2001 and was tested in 2009 with H1N1 and again in 2014 with Ebola and now Zika. Each time this country is faced with a new infectious disease threat, it feels like we're not as prepared as we should be. Most importantly, it seems like we're always behind the eight ball developing an effective vaccine or treatment. The Zika virus seems like a perfect example of this problem. We've known the virus could threaten Americans for some time, yet are just now committing serious resources and energy into combating the virus. The Blue Ribbon Study Panel on Biodefense, Chaired by Lieberman and Ridge, recognized this problem and recommended that HHS look at new incentives that could improve industry and academic participation in the development of medical countermeasures. It seems that policies like advanced appropriations and development incentives, had they been in place, would have dramatically improved our ability to respond to a threat like Zika virus. Do you believe additional incentives are needed to get the private sector involved in medical countermeasure development? And if so, what do you feel those additional incentives may include?

Response:

The emergence of Zika virus in the Americas and knowledge about the risk of Zika virus – particularly among pregnant women and women of childbearing age – is fairly recent. Since late last year, the Administration has been aggressively working to combat Zika. In developing CBRN and pandemic influenza MCMs, BARDA has coupled a mandate to act with a specific mission in a setting where ample resources are provided and the high risk and long timelines of product development are tolerated. BARDA and the PHEMCE have made substantial investments over the last five years in improving the U.S. Government's ability to partner effectively with the private sector. These improvements have been reflected in the increasing pace of product approvals. Of the 23 products supported by BARDA that have achieved licensure, approval, or clearance since 2007, 15 of these have reached this milestone since 2011 and five have done so in the last 12 months. We have worked closely with private sector partners and have taken steps to address their needs. Our success as measured in terms of approved or licensed products demonstrates that the system is working as intended. In considering additional incentives it is important to carefully targeted approaches to address identified barriers or problems. Certainly, dedicated funding to support the development of MCMs against EIDs is important.

Harris 1- Biosecurity Threats, medical countermeasures

- d. In the Public Health and Social Services Emergency Fund (PHSSEF) no-year funding is proposed language that provides authority not only for Zika but any infections disease, what is the scope of the potential uses of these funds? What was the basis for the provision allowing HHS to permanently change Project Bioshield authority for procurement of counter measures associated with the Department of Homeland Security Material Threat Assessment to HHS-based determinations?

Response:

Under the PHEMCE, ASPR has supported a robust advanced research and development pipeline and late-stage development and procurement of numerous MCMs under Project BioShield to address chemical, biological, radiological and nuclear (CBRN) threats. As a result, the nation is better prepared today to respond to CBRN threats. ASPR has also learned that development of one-drug for one-bug technologies, while important for their intended use, is not cost-effective. ASPR/BARDA has been moving forward based on lessons learned from our responses to pandemic influenza and Ebola; and investing in innovative platform technologies that may be able to address future EIDs while still supporting development of MCMs for CBRN and pandemic influenza threats. Investing in platform technologies will assist in rapidly developing vaccines, therapeutics, and diagnostics without having to start from scratch because the technologies have been previously proven or evaluated. The proposed expansion of the authorities under Project BioShield is included to allow for maximum flexibility in addressing our mission of preparing the nation for CBRN threats.

Harris 2- State Based Exchanges

The Affordable Care Act (ACA) allowed HHS to provide an estimated \$5.4 billion to the 14 states that desired to use the State Based Exchange program. The law does not allow these funds to be used for exchange operations and HHS is not allowed to issue grants after January 1, 2015. I understand that at least \$1.2 billion was not spent as of 3rd quarter FY 2015. These State-Based Exchanges have now been established. Please describe the timeframe and plan to recover any available State-Based Exchange Establishment grant funds back to the Treasury and how HHS expects to sweep up future funds that may become available in these States due to contract closure and other recoveries?

Response:

CMS reviews the State-based Marketplaces' proposed operating budgets to confirm funds are allocated according to federal requirements. CMS also follows established processes to monitor grant spending. Section 1311 grants are closed out once the grantee has completed all the work associated with a grant agreement or the end date for the grant has arrived, or both. As of November 30, 2015, over \$300 million of the 1311 funding awarded has been deobligated and returned to the federal government. In addition, Maryland has agreed to return \$32.5 million to the federal government due to their legal settlement with their contractor. CMS is in the process of collecting and returning more of the grant funds to the federal government through the grant closeout process, as well as through audits that identify any unallowable costs. In June 2015, CMS released FAQs to clarify the appropriate use of 1311 funds for establishment activities.¹⁰

¹⁰ <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FINAL-1311-FAQ-06-08-15.pdf>

Harris 3- Use of Discretionary Funds for Marketplaces

Why are marketplace exchange program integrity funds largely coming from discretionary funds rather than the user fees that were designated for this function by law?

Response:

Certain Marketplace activities are considered the responsibility of HHS under the statute, and therefore are not considered a special benefit for which user fees are eligible. An example is the Secretary's responsibility to develop and implement a quality improvement strategy for qualified health plans. CMS outlines all activities that are eligible to be funded through user fees in the annual Notice of Benefit and Payment Parameters rulemaking. CMS requests discretionary funds to cover activities that are not fully user fee eligible, including many program integrity activities.

Harris 4- Biotech Research and Medical Innovation

As the NIH itself has noted, “Requiring direct financial recoupment of the federal investment in biomedical research can potentially impede the development of promising technologies by causing [the] industry to be unwilling to license federally funded technologies” If the risk of the government marching in and acquiring a particular technology increases, the private sector may be hesitant or unwilling to license the technology, potentially impeding progress against some of our most costly and challenging diseases to the detriment of public health and safety. Can you explain how you think increasing the risk and uncertainty associated with supporting small biotech start-ups might chill venture and other private capital investment to the detriment of continued medical innovation?

Response:

The quote referenced in your question is drawn from a 2001 report submitted by NIH to Congress in response to FY 2001 appropriations report language that called on the agency to address “mounting concern over the cost to patients of therapeutic drugs” by preparing a plan to ensure that taxpayers’ interests are protected. The report, which is available at <http://www.ott.nih.gov/sites/default/files/documents/policy/wydenrpt.pdf>, concluded that technology transfer policies have resulted in a dramatic return to the taxpayer through the discovery of new technologies that reduce mortality, improve the quality of life, and result in economic development.

Using the government’s march-in authority is a complicated issue. This authority can be used for inventions funded by the government and determinations are made on a case by case basis. When it comes to drugs, only a fraction might have resulted from such public funding. Furthermore, certain criteria must be met if the government wanted to exercise its march in authority for those drugs developed with public dollars. These criteria assess whether reasonable attempts have been made to bring these inventions to the market or if there is a health and safety need. To date, NIH investigations have not shown these criteria to have been met. Accordingly, NIH does not believe there is any increased risk to the biotech community that stems from the way it currently applies its authorities under the Bayh-Dole Act.

The 2001 report also stated that federally funded biomedical research, aided by the economic incentives of Bayh-Dole, has created the scientific capital of knowledge that fuels medical and biotechnology development. Its conclusion that American taxpayers have been the beneficiaries of the remarkable medical advances that have come from this enterprise is just as true today as it was in 2001.

Harris 5- IPAB

With regards to IPAB, the FY17 budget proposes that starting in 2018 the target rate for GDP per capita growth be lowered from plus 1 percentage point to GDP plus 0.5 percent. If adopted, this would likely trigger the IPAB.

- a. Should an IPAB Committee fail to be appointed, does HHS have any draft IPAB proposals given the Secretary's role in promulgating such a proposal?
- b. How do you currently structure the decision-making process within HHS for determining such a proposal?

Response:

The Chief Actuary of the Centers for Medicare and Medicaid Services (OACT) determines in the annual Medicare Trustees' Report when IPAB is triggered. According to the 2015 Trustee's Report, IPAB will not be triggered for an implementation year before 2019. The President's Budget includes more than \$419 billion in net Medicare savings that would continue our current efforts to improve quality and efficiency in Medicare and improve the fiscal sustainability of the program. The Chief Actuary has not determined that IPAB has been triggered, and therefore, there has not yet been a requirement to develop a proposal

Harris 6- Part B Drug Payment

- a. As HHS/CMS seeks to implement a mandatory demonstration under CMMI regarding payment levels for most Part B drugs, will you seek stakeholder engagement through the notice and comment rulemaking?
- b. Please provide more details regarding this plan including: where will it be tested (where will be the testing versus control groups), when do you anticipate this project occurring, and what deficit of care did you CMMI identify as the basis for the testing?
- c. As you know, many of the patients who use Part B drugs are patients with cancer, autoimmune conditions, and other serious illnesses who have few or no other treatment options. How will you ensure that abrupt reimbursement changes in this model will not negatively impact access to needed care for these patients? Specifically, what steps are you taking to protect patient access and care quality?

Response:

- a. This past fall, HHS convened a forum that brought together consumers, providers, employers, manufacturers, health insurance companies, representatives from state and federal government, and other stakeholders to discuss ideas on how our country can meet the dual imperatives of encouraging drug development and innovation while protecting access and affordability. We came away with feedback to address these challenges in a holistic fashion addressing three important areas: (1) increasing access to information to support better health care decisions, (2) driving innovation that can improve and save lives, (3) and strengthening incentives in the delivery system to reward quality care to patients and encourage value-based and outcomes-based decision making.

Coming out of that forum, we identified several areas of opportunity for collaborative policy development. The need for better information about drug prices, and the potential impact that can have for patients and providers in making better health care decisions, was one theme that we heard across multiple panels. To that end, in December, we took a first step forward by providing more detailed information on Medicare spending on prescription drugs, for both Part B (primarily drugs administered in doctors' offices and other hospital outpatient settings) and Part D (primarily drugs patients take themselves) to better inform decision making. The Medicare Drug Spending Dashboard provides important information to the public in an accessible format, and serves as a first step to provide information that can enrich the picture.

We are examining potential ways to support increased access to information, drive innovation, and strengthen incentives to improve quality care. We continue to look at a number of options in this area.

- b. We are examining potential ways to support increased access to information, drive innovation, and strengthen incentives to improve quality care. For any model tested by the Innovation Center, we carefully consider the most appropriate design for implementing the model so that patients are protected while quality and spending can be meaningfully evaluated.

- c. Making certain that our beneficiaries receive high quality health care – and that the quality of their care improves over time – is one of our most important goals. For every model tested, CMS does this in two ways—real-time monitoring and rapid-cycle evaluation. First, each model has a monitoring strategy that is customized to the specific circumstances and model financial structure. Before launching a model, CMS carefully considers unintended consequences, and designs monitoring strategies that actively check for such adverse outcomes. By receiving regular updates from 1-800-MEDICARE, a model team can quickly learn of any potential issues as they arise. Other monitoring strategies include: analysis of claims data to identify abnormal billing patterns, audits of participants, and analysis of EHR-based quality measures.

Second, every model has a rigorous, yet rapid-cycle, evaluation conducted by an independent team that unfolds concurrently with model implementation. A key component of each evaluation is measuring care quality. While each model is different and requires a customized evaluation approach, common components include: regular surveys of beneficiary experience of care, analysis of claims-based quality of care outcomes, and qualitative data collection, such as patient and caregiver focus groups. By conducting these activities as the model is implemented, the evaluation can quickly identify potential issues with care quality and access and allow CMS to take action.

Harris 7- Human Donor Milk

- a. In regards to human donor milk, does HHS consider the product as a human biologic?
- b. And, are there any plans for standards or tests related to this product, particularly for those potentially used clinical medical settings with vulnerable pediatric populations? (eg, screening for disease, drugs of common abuse, etc.)

Response:

- a. Human breast milk meets the definition of food in the Federal Food, Drug, and Cosmetic Act (FD&C Act). Certain infant products containing human breast milk meet the FD&C Act definition of infant formula.
- b. FDA has issued recommendations against the use of human milk obtained directly from individuals or through the Internet, because it is unclear whether the donor has been adequately screened for infectious disease or contamination risk. In addition, it is unclear whether the human milk has been collected, processed, tested or stored in a way that reduces possible safety risks to the baby. FDA further recommends that if, after consultation with a healthcare provider, a person who decides to feed a baby with human milk from a source other than the baby's mother should only use milk from a source that has screened its milk donors and taken other precautions to ensure the safety of its milk. The FDA recommendations on the use of donor milk are available at the following link:
www.fda.gov/scienceresearch/specialtopics/pediatrictherapeuticsresearch/ucm235203.htm.

We held a Pediatric Advisory Committee meeting on the topic of human milk banking in December 2010, and continue to monitor developments in sales of human breast milk and human milk-based products as well as voluntary human milk banking. We currently do not have plans to issue regulations on donor human milk or voluntary donor human milk banks. We note that human milk intended for use by hospitalized infants is largely supplied through voluntary, independent milk banking consortiums.

We also note that some states require safety standards for milk banks. Additionally, some human milk banks voluntarily take steps to screen milk donors and to collect, process, handle, test, and store the milk in a way that they consider will reduce possible safety risks to the baby. Caregivers can contact their state's department of health to find out if it has information on human milk banks in their area. Another source of information is the Human Milk Banking Association of North America (HMBANA), a professional association for human milk banks that issues voluntary safety guidelines for member banks on screening donors, and collecting, processing, handling, testing and storing milk.

Harris 8- ASP Reimbursement Rates

- a. Are you considering additional payment changes beyond modifications to ASP reimbursement rates?
- b. What additional payment changes is CMS considering beyond modifications to the ASP reimbursement rate?
- c. How will CMS select the drugs to which these additional payment modifications will apply?

Response:

We are examining potential ways to support increased access to information, drive innovation, and strengthen incentives to improve quality care. We continue to look at a number of options in this area.

Harris 9- NCI Director

During your testimony, you highlighted the “cancer moonshot.” Could you provide an update on the status of appointing the NCI Director?

Response:

As you are aware, this position is a Presidential appointee. We will continue to work to fill this position with a highly qualified candidate that will help lead the Agency's efforts on critical cancer research. We look forward to sharing additional information when available.

Dr. Douglas Lowy, a renowned cancer researcher, is serving as the Acting Director of NCI and he has agreed to serve in this capacity for the duration of the Administration. I am grateful for his leadership.

Harris 10- Incarceration and subsidy eligibility

- a. Why does CMS consider the SSA Prisoner Update Process System (PUPS) data reliable for Medicare eligibility, yet unreliable for ACA enrollment verification?
- b. How long does HHS intend to accept self-attestation of non-incarceration status to serve as a valid response to related subsidy appeals?

Response:

HHS continues to use PUPS as a trusted data source to verify applicants' incarceration status, but does not rely solely on PUPS. The Marketplace accepts the application filer's incarceration attestation for purposes of determining eligibility, but does not terminate an applicant's enrollment in coverage through the Marketplace based only on information in PUPS about incarceration status. This is because HHS has determined that the PUPS database, as presently available, is not sufficiently current or accurate for use for this purpose. HHS is working with SSA to strengthen the quality of the data and will reassess the decision once improvements have been made.

Harris 11- Lab Developed Tests

In October of 2014, FDA released a draft guidance that sets forth a proposed framework to regulate laboratory developed tests (LDTs). The draft guidance treats these laboratory services as medical devices, which is the same pathway also used to regulate MRI machines and artificial joints. A recent report indicates there are more than 50,000 LDTs for hereditary diseases offered by CLIA-certified labs and that tally doesn't include the other types of LDTs such as those for infectious disease or oncology. According to your website, last year, FDA approved or cleared fewer than 50 devices. For the FDA to undertake regulation of 10s of thousands of LDTs, more than 50 devices a year will need to be approved or cleared to avoid a massive disruption in patient care.

- a. Do you anticipate a significant funding request to review all of these LDTs within the intended time frames?
- b. How much additional funding will you need to avoid any delays in patient access to these innovative tests?

As a physician, it is my understanding that the FDA does not regulate the practice of medicine. Pathologists are physicians. They and Board certified doctoral scientists develop and perform procedures and carry malpractice insurance. If the FDA finalizes its guidance to regulate these professionals as device manufacturers, they will be subject to the medical device tax and risk product liability claims, and I fear, more consequences from a policy that isn't appropriate for medical practice. Further, LDTs are already heavily regulated by the CLIA program at the Centers for Medicare & Medicaid Services, state regulations, and accrediting organizations.

- c. Please explain why you believe laboratory procedures should be subject to the same regulations as artificial hip replacements and cardiac stents?
- d. Why is it necessary to have two agencies regulating the performance of these procedures, and how, specifically, will you avoid redundancy?

Response:

- a. FDA does not anticipate requesting additional Congressional appropriations for the review of LDTs under its guidance approach. FDA acknowledges that LDTs will add to the Agency's workload; however, FDA has proposed an oversight approach in the draft LDT policy guidance document that would allow us to manage the number of applications FDA receives without requiring additional funding or affecting review times.

Specifically, FDA proposed a risk-based, measured oversight approach for LDTs that would phase in enforcement of the premarket review and other regulatory requirements over time. This phased-in approach provides time for LDT manufacturers to take the appropriate steps to ensure compliance with applicable regulations and allows FDA to rely on existing resources to conduct premarket review of LDTs. Our proposal would initially phase in enforcement of the premarket review requirements for some high-risk LDTs (by our estimate, a small fraction of LDTs on the market) and phase in enforcement of the premarket review requirements for other high-risk and moderate-risk LDTs over several years. Additionally, the draft LDT policy guidance document described categories of tests

that would generally remain under continued enforcement discretion with respect to premarket review and other requirements because the risks associated with those tests are adequately mitigated by other factors. The categories of tests include: LDTs for rare diseases (where the number of persons who may be tested with the LDT is fewer than 4,000 per year in the US), “traditional” LDTs (LDTs made of legally marketed components and which rely on the expertise and technique of laboratory professionals for interpretation rather than automated software or instrumentation, among other factors), and LDTs for unmet needs (tests for a specific intended use for which there is no FDA cleared or approved test available, among other factors). FDA anticipates that exercising enforcement discretion for these categories of LDTs will help us manage our workload.

Based on comments FDA received on the draft guidance, FDA anticipates modifying the proposed policy for LDTs to further reduce premarket review workload, which will help ensure that FDA can implement the LDT policy with existing resources.

Finally, FDA anticipates leveraging third party reviewers for the review of eligible moderate-risk LDTs. FDA currently has a third party review program and has proposed improvements to the program as part of the medical device user fee reauthorization process. FDA has invited various organizations to discuss this process with the Agency in the hopes they may be eligible to become approved third party reviewers.

Note that FDA approved or cleared significantly more than 50 devices last year and that approval and clearance figures are not accurate indicators of the volume of submissions FDA reviews. Annually, on average, FDA reviews more than 3,000 premarket notification (510(k)) submissions, more than 45 original premarket approval application (PMA) submissions, and more than 400 PMA supplement submissions. FDA clears more than 95% of 510(k) submissions they review, approve more than 80% of PMAs they review, and approve more than 90% of PMA supplements they review.

- b. FDA’s proposed approach does not require additional funding from Congress and it maintains patient access to tests while assuring those tests are accurate and reliable. Under FDA’s proposal in the draft LDT policy guidance document, FDA intends to phase in enforcement of the premarket review requirements for some high- and moderate-risk tests and continue exercising enforcement discretion while the premarket submissions for such tests are under review. If the sponsor or applicant is unable to demonstrate that its test is safe and effective for its intended use (e.g., either independently in a PMA or comparatively in a 510(k)), then FDA expects that such test would not remain on the market.
- c. LDTs are a subset of *in vitro* diagnostic devices (IVD) that are intended for clinical use and designed, manufactured, and used within a single laboratory. FDA has had the authority to regulate LDTs as devices since Congress amended the device definition in the Federal Food, Drug, and Cosmetic Act (FD&C Act), through the Medical Device Amendments of 1976, to include all *in vitro* diagnostics. However, for many years, FDA has generally exercised enforcement discretion (in that FDA has generally not been enforcing the applicable regulatory

requirements) with respect to LDTs. FDA believes that generally exercising enforcement discretion with respect to LDTs is no longer appropriate because LDTs today present greater risk, and therefore, FDA has proposed to modify its enforcement policy as described in the draft guidance. Due to advances in technology and changes in business models, LDTs have evolved from being relatively simple tests that were generally only available on a limited basis to complex tests that have a nation-wide reach and have higher risk uses, such as predicting breast cancer risk and directing critical treatment decisions, similar to those of other IVDs which have undergone FDA premarket review. FDA oversight is needed to assure that LDTs used in making major medical decisions are safe and effective. Patients and their healthcare providers should be able to rely on these tests for clinical decision-making.

- d. CMS and FDA have complementary but different roles. CMS has oversight of laboratory operations while FDA assures devices are safe and effective.

Under CLIA, CMS specifies requirements for laboratory conditions, staffing (including whether laboratory personnel have appropriate training), specimen handling, reagents and equipment maintenance (including confirmation of expected performance specifications), and timely report out results such that a test system, as run in a particular laboratory, is done appropriately and provides analytically valid data. CMS does not conduct premarket reviews of LDTs to assess the analytical validity (e.g., analytical specificity and sensitivity, accuracy and precision) or clinical validity (i.e., the accuracy with which the test identifies, measures, or predicts the presence or absence of a clinical condition or predisposition in a patient) of a test. Unlike CMS, FDA has the authority and expertise to conduct in-depth, premarket reviews of tests to assure tests actually work as intended. A critical aspect of assuring safety and effectiveness of tests is FDA's premarket review of clinical validity, which is the accuracy with which the test identifies, measures, or predicts the presence or absence of a clinical condition or predisposition in a patient. FDA looks at both analytical and clinical validity, which are interrelated, and ultimately determines if a test will perform as intended for patients in a specific population. FDA premarket review of tests are generally performed by teams of scientific and medical specialists, including physicians, medical technologists, biologists, geneticists, chemists, and statisticians with training and experience in reviewing test performance. CMS does not perform premarket review, nor do they have the expertise to assess clinical validity.

Further, the FDA is aware that, while CLIA requires analytical validation to ensure that an LDT is performing as expected by the developer of the test within the laboratory environment, CLIA does not assess whether or not the performance specifications established by the developer are adequate. FDA takes analytical validation a step further by assessing whether the performance of the test is adequate for its intended use. CLIA oversight also occurs *after* the device is already in use for providing clinical diagnostic results. Accordingly, with respect to LDTs, both CLIA and the FD&C Act are important to protect patient safety. FDA premarket review under the FD&C Act and FDA regulations are intended to assure safety and effectiveness.

To coordinate efforts across the Department of Health and Human Services, FDA and CMS established an interagency task force in April 2015 to continue and expand on our collaboration related to the oversight of LDTs. The Task Force, comprised of leaders and subject matter experts from each agency as well as NIH and CDC, is working to address a range of issues, including those involving quality requirements for LDTs. There is no set endpoint for the Task Force, which will continue operating as long as it is determined to be useful by the participating agencies.

The Task Force goals include:

- Clarifying FDA's and CMS' roles in the oversight of clinical laboratories that manufacture LDTs.
- Addressing the needs and concerns of clinical laboratories in regard to their development of LDTs, and how laboratories would implement the FDA Quality System regulation requirements.
- Investigating how to best leverage joint resources to develop appropriate training, avoid duplication, and maximize efficiency of efforts.

The first product of the Task Force was a joint blog, detailing FDA's and CMS' roles in the oversight of laboratories that manufacture LDTs. The blog was published on both FDA's and CMS CLIA's websites in April 2015. FDA also held meetings with each of the CLIA-approved accreditation organizations to discuss their survey processes.

Rigell 1- CMS Third Party Payments

In 2014, the Centers for Medicare and Medicaid Services (CMS) released an interim final rule entitled, *Third Party Payment of Qualified Health Plans*. This interim rule stated that CMS must accept third party payments from State AIDS Drug Assistance Programs, the Indian Health Service/Tribal Organizations, and any other state or federal program. The rule that went on to state that private insurance plans offered on the healthcare exchanges could have prohibitions against other forms of premium and payment assistance. In this country, there is a long and proud history of religious institutions, civic organizations, and qualified non-profit organization providing support and assistance for individuals impacted by rare, chronic, or costly medical conditions. Unsurprisingly, following the release of the interim rule, health plans in 37 states now restrict forms of assistance that the most vulnerable patients rely on to access quality healthcare and life-saving or life-sustaining therapies.

- a. Is there any rational reason why qualified non-profit organizations would be excluded from continuing to provide third party premium assistance?
- b. Relatedly, will CMS clarify this issue and include qualified nonprofit organizations as a required entity in the final rule or through other, more immediate, action?
- c. Finally, has CMS considered the impact of this language and the potential harm to patients if their charitable assistance is restricted and pre-existing condition discrimination returns?

Response:

The Affordable Care Act reformed the Health Insurance Marketplace to ensure that individuals with pre-existing conditions are able to access care by prohibiting insurance plans from discriminating against consumers with pre-existing conditions or charging them more because they got sick. In addition, for consumers who qualify, the ACA provides financial assistance to help consumers afford their premiums, and out-of-pocket expenses. These market reforms and financial assistance work together to ensure access to care.

In the Interim Final Rule referenced in the question, CMS required QHP issuers to accept payment from entities such as the Ryan White HIV/AIDS Program, tribes, tribal organizations and urban Indian organizations, in part because federal or state law authorizes third party payment of premium and cost-sharing amounts by these entities.

The Indian Health Care Improvement Act and implementing regulations of the Affordable Care Act provide that Marketplaces may permit Indian tribes, tribal organizations and urban Indian organizations to pay aggregated QHP premiums on behalf of qualified individuals, subject to terms and conditions determined by the Marketplace.

The Ryan White HIV/AIDS Program has been authorized to provide insurance assistance for low-income people living with HIV since 1990 under the Public Health Service Act. As of 2000, the Public Health Service Act provides authority for states to use AIDS Drug Assistance Program grant funds to purchase or maintain health insurance or plans when the coverage includes the relevant therapeutics and the cost of such coverage does not exceed the costs of otherwise providing the therapeutics directly.

Issuers may still choose to accept third party payments from non-profits, and in an FAQ published in February 2014¹¹, CMS noted that this is permitted so long as the criteria for premium assistance is based on financial need, not health status, and that the assistance continues through the entire plan year.

¹¹ <https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-payments-of-premiums-for-qualified-health-plans-in-the-marketplaces-2-7-14.pdf>

DeLauro 1- CCDBG

I think it's fair to say that we are all pleased that Congress came together in a nonpartisan fashion to support child care by strengthening health and safety requirements and improving access for families in the Child Care and Development Block Grant's recent reauthorization. I understand, however, that there are significant costs for States associated with full implementation of the new law.

- a. Can you please explain how the Department will help states to implement the new changes without more families losing child care, especially since 364,000 children have lost child care since 2006?
- b. Can you also comment on how child care quality can improve while child care providers are only making poverty wages?

Response:

- a. We appreciate the bipartisan work to reauthorize the child care law. We share your concern about the declining number of children served by the Federal child care program, particularly since only about 15% of children eligible under Federal rules currently receive a child care subsidy. We recognize that greater budgetary resources are needed to implement important provisions of the reauthorization—including twelve-month eligibility, health and safety training, criminal background checks, and annual inspections of child care providers receiving public dollars.

Since passage of the law, the President has requested increased funding for child care, including a significant expansion of mandatory funding of \$82 billion over 10 years focused on high quality care for infants and toddlers. The \$326 million discretionary increase provided for CCDBG in FY2016 will help defray some State costs of implementing the new law, but additional and sustained investments are still needed. To better meet the needs of states and to assist effective implementation efforts, the President's FY 2017 Budget requests \$2.962 billion in discretionary funding for the Child Care and Development Block Grant program, an increase of over \$200 million from the FY 2016 enacted levels. The Budget also includes a request for \$82 billion in additional mandatory funding over the next 10 years to ensure that all low- and moderate-income working families with young children have access to high-quality child care.

- b. The budget request includes \$82 billion in additional mandatory funding over ten years to ensure that all low- and moderate-income working families with children age three and below have access to affordable high-quality child care. These increased investments will not only ensure that more low-income children are in high-quality child care settings; they will also help support child care providers to hire, train, and retain highly skilled child care workers through a higher subsidy that covers the cost of high-quality care. Higher child care subsidy payments mean higher payments to child care providers, which in turn enable providers to pay their workers better. A stronger subsidy has the potential to broaden the set of child care options that families can access, improve the working conditions and wages of the child care workforce, and in turn, improve the quality of care provided. With an increased average annual subsidy, child care providers can increase wages in order to reduce turnover and improve the continuity of caregiver relationships with children.

DeLauro 2- Head Start

We made genuine progress last year for early childhood education. We boosted Head Start by \$570 million, which included an increase of \$135 million to expand Early Head Start-Child Care Partnerships. I want to thank Chairman Cole for being a strong champion of Head Start. But there are almost 6 million children ages 5 and younger living in poverty in the United States. Given budget constraints, we were able to fund Head Start and Early Head Start slots for less than 1 million of those children in FY 2016, leaving over 5 million infants and toddlers—and their families—without access to Head Start services.

This is an example of the unmet need for early childhood education. We are barely scratching the surface. I will say it again – we need a strong allocation so we can build on the progress we made last year. I am pleased to see that the Head Start budget requests an increase in FY 2017 to further expand full-day, full-year services.

- a. Can you tell us how the transition to full day/full year services is going so far for the Head Start centers that are transitioning in 2016? Are there lessons learned for FY 2017?
- b. The budget requests an additional \$292 million in FY 2017 to further expand full-day, full-year services. Yet I'm told that more than half of Head Start kids are still not receiving full day services. Do you have an estimate of how much it would cost to extend full day services to 100 percent of children served by Head Start?

Response:

- a. We appreciate the initial investment of \$294 million that Congress provided to expand the duration of Head Start and Early Head Start programs. HHS is currently finalizing the policy and process for distributing these funds and expects to issue a Program Instruction soon inviting eligible grantees to voluntarily apply for this funding. While we expect to learn a great deal more as we implement these changes later this year, we have learned that allowing programs some flexibility to design a longer day and year in a manner that best meets their community's needs is critical to the success of this effort. This funding will be awarded no later than December 31, 2016.
- b. In June 2015, HHS proposed revisions to the program regulations that included new minimum service requirements for Head Start programs that estimated the average annual cost of immediate, full implementation, rather than staging increases across multiple years, at about \$1.1 billion. The FY 2016 funds will make a significant down payment toward the goal of offering full day and year services to nearly all Head Start children. However, we will need additional funds in FY 2017 and beyond to continue to make progress toward this goal. The President's FY 2017 Budget requests an additional \$292 million to allow programs to further expand the duration of their services, building on the initial duration investments provided in 2016. The request reflects a multi-year path to full implementation of a policy under which Head Start programs will receive financial support to transition all slots to a full school day and year, with some exceptions being made for local circumstances.

DeLauro 3- DSH Payments

- a. The Committee report accompanying the 2016 Omnibus Appropriations Act called on the Department to report in 90 days regarding its one year policy change, later reversed, regarding hospital mergers and the financial impact on hospital DSH payments of this abrupt change. Can we expect that report soon?
- b. How does the Department explain CMS's abrupt change in policy in 2014 for hospital mergers and DSH payments, then, fortunately, reversed in 2015?
- c. Why did CMS not provide notice with opportunity to comment?
- d. And, in light of this situation, when CMS ignores notice and comment, why should Congress not reinstate the opportunity for administrative and judicial appeal?

Response:

Our change with regard to the treatment of merged hospitals in other policy areas was adopted through notice and comment rulemaking in both the FY 2014 IPPS Final Rule (78 FR 50642) and FY 2015 IPPS Rule (79 FR 50021). Specifically, we received a public comment on the FY 2014 proposed rule pointing out that CMS used only the surviving hospital's data to determine the uncompensated care allocation for two hospitals that merged and requesting that CMS include both hospitals' data. In response, we described that we computed the uncompensated care allocation using the data associated with a provider's CMS Certification Number, and that this was consistent with a number of other IPPS payment factors, such as Medicare disproportionate share adjustments, cost to charge ratios for outlier payments, and wage index values. In FY 2015, through notice and comment rulemaking, we adjusted this policy in response to public comment. With regard to the report, CMS is working to complete the report requested.

DeLauro 4- Access to Prosthetic Care for Seniors

In 2015, NIHC, one of CMS's four Durable Medical Equipment Medicare Administrative Contractors published a proposed Local Coverage Determination (LCD) for Lower Limb Prostheses (DL333787). The proposed policy would limit access to modern prosthetic care for veterans in multiple ways. I understand that CMS has advised Members of Congress that the business relationship between CMS and its contractors limits CMS's ability to recommend or require revisions to LCD proposals to assure that such LCD documents reflect seniors' concerns and relevant clinical information.

- a. Can you explain to the Committee why CMS lacks the ability to oversee, manage and direct its own contractors?
- b. Under the proposed LCD, several procedural codes that represent different prosthetic feet and ankles would be consolidated into a generic single code, resulting in seniors, veterans and others being denied access to medically necessary, appropriate modern technology. What is the justification for consolidating codes that represent different prosthetic technology into a single code?
- c. The draft LCD would base a patient's "functional level" on his or her current capacity to ambulate while wearing a prosthesis, not on the potential to improve mobility through the use of advanced prosthetic devices. This would reverse several decades of policy where the focus did indeed consider strongly the patient's 'potential' to improve their mobility, designed to help patients return to their maximum functional level, activities of daily living, and employment. What is the justification for basing a patient's functional level on current capacity instead of their potential to recover to their greatest physical mobility?
- d. Currently, only half of Medicare beneficiaries who have undergone amputation receive a prescription for a prosthesis. Even without the restrictions outlined by the proposed LCD, Medicare expenditure on advanced technology has steadily declined in the past several years, and currently represents less than one-third of one percent of Medicare expenditures. What is the clinical justification for the proposed changes in the LCD?
- e. Is this proposed policy driven primarily by an effort to control costs?
- f. What is the anticipated cost savings of the proposed policy?
- g. In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Congress in section 427 instructed CMS not to pay anyone who provides prosthetics and orthotics to Medicare beneficiaries unless that provider is either licensed (in states that have enacted licensure requirements), or accredited in accordance with criteria by two of the then-leading accrediting bodies, with the requirement that regulations be enacted within 12 months. We are in the 16th year since that statute was enacted, and there are still no implementing regulations. What is the explanation for this delay, and what is the plan for implementing the law?

Response:

a-f. Section 522 of the Benefits Improvement and Protection Act (BIPA) codified and defined the term "local coverage determination" (LCD). A Medicare LCD is a decision by a Medicare Administrative Contractor (MAC) on whether or not to cover a particular item or service on a contractor-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the item or service is "reasonable and necessary" for the diagnosis or treatment of an illness or injury

or to improve the functioning of a malformed body part). The MACs develop LCDs by considering medical literature, the advice of local medical societies and medical consultants, public comments, and comments from the provider community. In the case of coverage for durable medical equipment (DME), the four specialized DME MACs are required to have identical LCDs; thus, for DME, there is no regional variation in coverage.

The Centers for Medicare & Medicaid Services (CMS) is committed to providing high quality care to all Medicare beneficiaries, including any beneficiary in need of a prosthesis. Both CMS and its contractors are aware of concerns about access to prostheses for Medicare beneficiaries. In addition, public comments generated by the draft Lower Limb Prostheses Local Coverage Determination (LCD) highlighted clinical questions and evidence gaps associated with the provision of lower limb prostheses to our beneficiaries. Thus, the DME MACs decided not to finalize the draft LCD at this time.

Instead, CMS convened a multidisciplinary Lower Limb Prostheses Interagency Work Group to develop a consensus statement to inform Medicare policy based on a review of the available clinical evidence on best practices in the care of beneficiaries who require lower limb prostheses. The Work Group is comprised of clinicians, researchers, policy specialists, and patient advocates from several federal agencies. The Work Group may also identify areas where evidence gaps exist related to the prescription of lower extremity prostheses, and make recommendations on study designs and outcome measures that best inform patient-oriented function, quality of life, and service satisfaction in this area. CMS will ensure there is opportunity for public comment and engagement on the Work Group consensus statement and any related activities to ensure appropriate access to prostheses.

g. While CMS has not yet implemented certain provisions of BIPA through rulemaking, the agency has prioritized significant activities to promote quality of Medicare-enrolled Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) suppliers, as well as to prevent payments to unlicensed DMEPOS suppliers. For example, CMS has put safeguards in place to verify that only licensed, qualified, and accredited suppliers are furnishing DMEPOS items to beneficiaries. Additionally, CMS has implemented quality standards and accreditation requirements, which are an important part of efforts to ensure that only qualified providers and suppliers are able to provide and bill for services and supplies. CMS also verifies that orthotic and prosthetic suppliers meet applicable state licensure and certification requirements before paying for Medicare services.

Lowey 1- BARDA

Through public-private partnerships, BARDA has made tremendous progress toward meeting the goal of having a flexible and modern countermeasure enterprise that can deliver safe and effective medical products quickly during health emergencies.

- a. Do existing agreements provide BARDA with the resources it needs to respond to medical emergencies quickly?
- b. If not, what level of funding and authority does BARDA need to ensure that critical medical countermeasures to combat Ebola, Zika, and the next epidemic are available to rapidly combat emerging health threats?

Response:

The Office of the Assistant Secretary for Preparedness and Response (ASPR)/Biomedical Advanced Research and Development Authority (BARDA) utilizes all available contractual options to respond to emergencies quickly, and has utilized different authorities or agreements to respond to different public health emergencies. These include letter contract awards and cooperative agreements. BARDA has leveraged additional resources made possible through the Ebola emergency appropriation to address Ebola response and preparedness activities. BARDA was able to coordinate with our Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) partners to expedite development of vaccines, therapeutics and diagnostics against Ebola. Without the supplemental funding, BARDA would not have had sufficient funds to engage with our PHEMCE partners and pull these projects into advanced development. BARDA will require supplemental funding to respond to the Zika crisis. Without additional funding, BARDA will be unable to respond or will have to reduce funding for another effort in order to respond to this public health crisis.

As has been observed in Guinea in the late March of this year, there was another outbreak of Ebola; requiring tracing, tracking and potential vaccination of approximately 1000 individuals. This recent flare-up highlights the vigilance that is necessary to ensure we complete our mission to develop effective vaccines, therapeutics and diagnostics with funds that were provided for Ebola and not divert these funds to address the next health crisis.

The Administration's Zika supplemental request included \$1.5 billion for HHS, including funds to focus on development of vaccines, diagnostics, and pathogen reduction technologies to address Zika. The requested funding is critical for BARDA to have a meaningful impact on the current crisis and to leverage investments by our PHEMCE partners to develop effective vaccines, diagnostics and pathogen reduction technologies.

Roybal-Allard 1- Newborn Screening

Your budget requested \$13.9 million to continue the critical programs of the Heritable Disorders Program established by the Newborn Screening Saves Lives Act, including the work of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children. There were several ongoing and new initiatives discussed in your budget justification that will facilitate timely and comprehensive newborn screening and follow-up treatment in every state, and I would like to ask you some questions about these initiatives.

- a. Now that you are in the second year of the Improving Timeliness of Newborn Screening Diagnosis initiative, have you seen an increase in the number of states that meet the Committee's recommendations on timeliness for receiving diagnosis and treatment of newborn disorders?
- b. In recent years, the committee has added several new conditions to the Recommended Uniform Screening Panel (RUSP), including SCID and Pompe, and just this month you accepted the Committee's recommendations to add MSP (Mucopolysaccharidosis) and ALD (Adrenoleukodystrophy). How will HRSA use the requested funds to help states incorporate these newly recommended conditions into their newborn screening panels?
- c. I recently visited the *Baby's First Test website* and was very impressed with its content and delivery, as well as the fact that you have made it available in a comprehensive Spanish version. How are you promoting awareness of this tool in Hispanic communities, and are you tracking usage of the Spanish section of the website?

Response:

Thank you for your commitment to this issue. Universal newborn screening provides early identification and follow-up for treatment of infants affected by certain genetic, metabolic, hormonal and/or functional conditions. As you know, newborn screening saves or improves the lives of more than 12,000 babies in the United States each year.

- a. The Improving Timeliness of Newborn Screening Diagnosis initiative began in September 2015 and has not yet completed a full year. Twenty states met on January 21-22, 2016 for a kickoff meeting focused on introducing the Newborn Screening program teams to the continuous quality improvement process. As you know, the overall objectives for this initiative are to increase the number of states that meet the Committee's recommendations on timeliness and to increase the number of infants receiving timely diagnosis and treatment. To do so, activities include coordinating collaborative learning and quality improvement activities in newborn screening programs using practice-based strategies that improve timeliness.
- b. A funding opportunity announcement was released in March 2016 called the Newborn Screening Implementation Program Regarding Conditions Added to the Recommended Uniform Screening Panel (HRSA-16-062). This initiative supports states with the implementation, education, and awareness of newborn screening for those conditions recently added to the RUSP including Pompe Disease, Mucopolysaccharidosis I (MPS I), and X-linked Adrenoleukodystrophy (X-ALD). The purpose of this program is to increase the number of states and/or territories that include screening for these newly added conditions on the RUSP as

part of their newborn screening program. The program will also disseminate national, regional, and state education and training resources for parents, families, and providers. For more information see: <http://www.grants.gov/web/grants/view-opportunity.html?oppId=282584>.

- c. We appreciate your thoughts, and share your commitment to ensuring that the resource is disseminated widely. The grantee is reaching out to a range of partners for dissemination. Currently, the grantee is working with the Text4Baby team at Zero to Three, the National Center for Infants, Toddlers and Families, to update the current newborn screening messaging to include a link to the Spanish site (the English site already is included in Text4Baby). The grantee is also working with the National Council of La Raza regarding opportunities to be included in their newsletter to increase awareness about this resource. They are also working with various state newborn screening programs to link to the Spanish site so that it can be a resource for people looking specifically at what their state screens for during the newborn phase. The grantee has started tracking usage of the Spanish site and hopes to see an increase in 2016 after their planned outreach campaign later this year.

Roybal-Allard 2- CHGME

The 55 Children's Hospitals that receive Children's Hospital Graduate Medical Education funding represent only one percent of all hospitals, but they train 49% of our nation's pediatric workforce. For that reason I was pleased that the President's budget reflects a commitment to the importance of strengthening the pediatric workforce, by recommending \$295 million in funding for the Children's Hospitals Graduate Medical Education (CHGME) program.

In past years this Administration has proposed significantly lower allocations for the CHGME program, although the Subcommittee has consistently restored its funding because we recognized the importance this program plays in supporting children's health.

- a. Why did the President's budget propose converting the CHGME program to one funded through mandatory funding, as is the case with other federal GME programs?
- b. Can you talk about how you see the CHGME program supporting the White House's health care goals?

Response:

- a. To provide a predictable funding stream for this program, consistent with graduate medical education (GME) support in other federal programs, the Budget proposes a five-year mandatory investment of nearly \$1.5 billion for Children's Hospital Graduate Medical Education. This is particularly important for Graduate Medical Education programs that require up to 5 years for an individual to complete training. For example, general pediatric residency programs require 3 total years of training, and child and adolescent psychiatry residency programs require 5 total years of training. This proposal is also consistent with recommendations from the Institute of Medicine.
- b. Through supporting the training of pediatric residents, the purpose of the CHGME program aligns with the HHS Strategic Plan, which seeks to ensure access to quality, culturally competent care, promote the safety, well-being, and healthy development of children and youth, and support prevention and wellness across the life span.

Compared with other teaching hospitals, freestanding children's hospitals receive little to no GME funding from Medicare because children's hospitals have such a low Medicare caseload. General pediatricians and pediatric subspecialists provide essential care to the pediatric population. CHGME hospitals train about 30 percent of the nation's pediatricians and nearly half of all pediatric sub-specialists. These programs are substantial contributors to the pediatric workforce that care for our nation's children.

Roybal-Allard 3- Unaccompanied Alien Children

I was truly shocked when I read about the release of unaccompanied minors from ORR care into the hands of human traffickers. The Permanent Subcommittee on Investigations in the U.S. Senate documented cases of children who were forced to work on egg farms around Marion, Ohio for twelve hours a day and up to six or seven days a week and were subsequently forced to surrender their paychecks. It is my understanding that sufficient steps were not taken to ensure that the sponsors would provide a safe environment.

This is truly appalling and unacceptable. One way to protect these children is through home studies which investigate the background of sponsors before children are released to them and through post release services in which HHS can continue to check in on a child.

- a. How much money is ORR requesting for home studies and post-release services and how did your Department arrive at that figure?
- b. What percentage of the children will be released to sponsors that have been screened through a home study and what percentage of the homes will be visited periodically under post -release services?
- c. In the event that there is an increased demand, how does the Department ensure that post release services and home studies are available?
- d. Under a pilot program announced by HHS on July 1, 2015, home studies are now required for all unaccompanied children 12 years of age and under who are to be placed with a Category 3 sponsor, which is a distant relative or unrelated individual. What is the Department's plan to continue and expand the pilot program?

Response:

- a. Operating the Unaccompanied Children Program presents challenges because of uncertainties regarding how many children will arrive and when. Incorporating lessons learned from the summer of 2014, when caseloads increased quickly, HHS has adjusted a number of its practices to more flexibly and efficiently respond to fluctuations in migration while also maintaining high standards of care for this vulnerable population. The FY 2017 President's budget request includes \$1,226,000,000 in base funding for the Unaccompanied Children Program, which covers support for shelter operations, medical services, background checks, legal services, home studies and post release services, and administration. Estimated budgets for post release services and home studies grants are based on the number of services required in prior fiscal years, but the total funding is often dependent on the number of children referred to ORR during the year, and has varied significantly in recent years. In FY 2016, the budget estimate for home studies is a total of \$7,000,000 and the budget estimate for post release services is \$21,000,000.
- b. In FY 2015, approximately 7 percent of sponsors received home studies as part of the sponsor assessment process and approximately 25 percent of unaccompanied children received post

release services. The number of unaccompanied children and sponsors who will receive home studies and post release services in FY 2016 will be dependent on the unique characteristics of each child referred to ORR during the year. In FY 2015, 87 percent of sponsors were parents or close family members.

- c. For FY 2017, as for FY 2016, the Administration has urged that Congress provide a Contingency Fund for the UC Program that would provide additional resources only if the number of UCs referred to HHS exceeded the number that can be accommodated with base funding. In a program with unpredictable fluctuations in arrivals, having such a fund is essential to both ensuring that we can provide shelter for all arriving children, and have the stable funding that it is critical to our efforts to provide services to children in and after they leave our care.
- d. As of February 25, 2016, ORR has not made a determination regarding plans to continue or expand the pilot program to require a home study for children 12 and under released to a non-relative sponsor. As of March 31, 2016, ORR has updated its policy to fully implement the pilot and require a home study for children who are 12 years and under before releasing to a non-relative sponsor.

Rovbal Allard 4- Drug Resistant Tuberculosis

In December 2015 the White House released the National Action Plan for Combating Multidrug-Resistant Tuberculosis (MDRTB), a thoughtful and comprehensive 5 year plan to develop new tools for diagnosis and treatment and new research investments for an effective TB vaccine. However your FY17 budget proposal did not include any designated funding for implementation of this action plan, and this raises concerns that the plan will be successful in reducing MDRTB infection both here in the United States and abroad.

- a. Why was there no funding request for this National Action Plan, and can you provide information for the Subcommittee on the implementation costs for the plan for both CDC and NIH?
- b. Are there other sources of funding for TB research in addition to NIH and CDC? For example, because of the antimicrobial resistant nature of drug resistant tuberculosis, could BARDA or the Combating Antimicrobial Resistant Bacteria (CARB) initiative play a role in supporting the development of more effective TB treatments?

Response:

- a. The FY 2017 Budget continues activities within CDC and NIH to advance the goals of the National Action Plan for Combating Multidrug-Resistant Tuberculosis (MDRTB). The Plan is intended to promote greater investment and coordination of U.S. Government resources to reduce the domestic and global risk of MDR-TB and to encourage other bilateral and multilateral donors, the private sector, and affected countries to invest additional resources in these important actions.

CDC's Division of TB Elimination will lead activities for achieving the goals of the Domestic section (Goal 1):

- a. Lay groundwork to upgrade TB surveillance, nationwide, to ensure complete and accurate detection of drug-resistant TB
- b. Explore ways to strengthen state and local capacity to prevent transmission of drug-resistant TB and create surge capacity for drug-resistant TB contact investigations
- c. Explore ways to ensure that patients with drug-resistant TB receive treatment until cured; potential options include creation of a small national TB stockpile of drugs, providing treatment options for those individuals with no medical home, and strengthening management of transnational cases

In addition, CDC will carry out activities in support of the Plan's research goals (Goal 3):

- d. Evaluate treatment regimens to treat drug-resistant TB
- e. Build evidence base for developing strategies to assure completion of therapy
- f. Study correlates of progression from TB infection to active disease
- g. Assess shorter MDR-TB regimens using existing TB drugs

Additionally, the National Institute of Allergy and Infectious Diseases (NIAID), the lead NIH Institute for research on tuberculosis (TB), is playing a critical role in the President's *National Action Plan for Combating Multidrug-resistant Tuberculosis* (MDR-TB). The Federal

Government objectives summarized in the *National Action Plan*'s Goal 3, Accelerate Basic and Applied Research and Development to Combat MDR-TB, are a focused subset of NIH's ongoing TB research programs that address the critical issue of MDR-TB. NIH will continue to support the full breadth of its existing TB research and development programs. In addition, recognizing the value of domestic and international research and development collaborations, NIH will work to facilitate and enhance existing Federal Government-supported research, as well as research of its domestic and international partners, to combat the emergence and spread of drug-resistant TB.

For example, a longstanding collaboration between NIAID and South Korean scientists focuses on human clinical trials of TB, particularly MDR-TB and extensively drug-resistant TB (XDR-TB). The researchers have shown that linezolid, a drug approved for treatment of other bacterial infections, produced stable long-term cures of patients with XDR-TB. This collaboration includes work designing and evaluating rapid diagnostics for drug resistance, surrogate immunologic markers for determining effective response to therapy, and MDR- and XDR-TB epidemiology.

In summary, NIAID is leveraging current and past investments in biomedical basic, translational, and clinical research for infectious diseases to inform critical scientific areas in TB research and to facilitate development of new drugs, vaccines and diagnostics to help prevent TB and the emergence of MDR- and XDR-TB. NIAID research has contributed to more than half of the current clinical pipeline of TB vaccine candidates, one third of the clinical pipeline of TB drugs and regimens, and many of the diagnostic candidates currently under evaluation. NIAID's TB research programs are built on the principle of collaboration and coordination with relevant stakeholders, strategies, and global funders of biomedical research and are positioned to complement and supplement global research and development.

b. The White House National Action Plan to Combat Multidrug-Resistant Tuberculosis was developed in response to the recommendations outlined in the National Action Plan for Combating Antibiotic Resistant Bacteria (CARB). It was drafted by an interagency TB Working Group with representation from the United States Agency for International Development (USAID); the National Institutes of Health (NIH); the Centers for Disease Control and Prevention (CDC); the Departments of State, Defense, Veterans Affairs, Homeland Security, and Health and Human Services (HHS); the Office of Science and Technology Policy (OSTP); the Office of Management and Budget; and the National Security Council, and builds on existing mandates of these U.S. Government departments and agencies to advance efforts such as those identified in the WHO's End TB Strategy and the U.S. Government's Global TB Strategy 2015–2019.

Rovbal-Allard 5- Navigators and Assistors

Enrollment assisters play a crucial role in providing on the ground support and community based education to consumers on their health insurance options, and facilitating consumer enrollment. Engaging hard to reach populations, assisting with post-enrollment issues, and helping to enroll consumers in Medicaid is year round work and navigator programs need a sustainable funding stream.

What is HHS doing to ensure that navigator programs in underserved communities and elsewhere are receiving the enhanced attention and resources necessary to provide adequate and sustainable assistance to consumers?

Response:

Navigators provide on-the-ground support and community-based education to consumers on their health insurance options as well as assistance in completing enrollment. In addition to assisting consumers during open enrollment, Navigators provide year-round assistance to assist consumers eligible for enrollment through special enrollment periods (SEPs), Medicaid or CHIP eligibility and enrollment, small businesses, eligibility redeterminations, and guidance on taxes. Navigators provide consumers, many of whom have limited experience with health insurance, with education on understanding their benefits and how to use their coverage. The Final HHS Notice of Benefit and Payment Parameters for 2017 expands the required duties of FFM Navigators to include specific post-enrollment and other assistance activities such as helping consumers understand the basic process of filing Marketplace eligibility appeals, helping consumers understand and apply for exemptions from the individual shared responsibility payment that are granted through the Marketplace, and helping consumers understand basic concepts and rights related to health coverage and how to use it.

The Enrollment Assistance Program (EAP) offers broad-based enrollment assistance programs to populations not covered or targeted by the Navigators. EAP offers CMS the flexibility to support enrollment by filling geographic and demographic gaps in in-person assistance ensuring all consumers can receive one-on-one assistance. CMS operates the Assister Help Resource Center (AHRC) to provide assisters help with policy questions and complex consumer issues.

In FY 2017, CMS will continue targeted education and awareness activities in local communities and provide significant one-on-one assistance for consumers in states served by the Federally Facilitated Marketplaces. CMS will continue to support at least two Navigator entities per State and provide EAP coverage to cover geographic and demographic gaps in Navigator coverage.

Roybal-Allard 6- Chronic Kidney Disease

NIH is focused on treatment and prevention of kidney disease, and is investing resources in slowing the progression of kidney disease. CDC strategies are focused on early detection of the disease, and controlling risk factors. As a result of the work done at NIH and CDC, great advances are being made that are providing physicians with tools to slow the progression of chronic kidney disease.

Earlier detection of chronic kidney disease among those at risk would allow for the introduction of existing, low-cost medical management strategies and patient education necessary to slow the progression of kidney disease, reduce the associated comorbidities, and better prepare those who do progress to kidney failure for dialysis or transplantation. However, reimbursement strategies at CMS do not seem to be incentivizing providers to intervene with those patients at risk.

- a. What steps could be taken by HHS to better promote early detection and treatment of chronic kidney disease?
- b. What strategies and incentives in reimbursement policy could incentivize providers to detect CKD in its early stages?
- c. What dis-incentives need to be eliminated from reimbursement policy to ensure that patients with CKD receive the treatment they need?
- d. What benefits exist to both patients and taxpayers as a result of slowing the rate of entry into the expensive ESRD program?

Response:

- a. HHS agrees that early detection and treatment of chronic kidney disease (CKD) is important, which is why one of the goals of Healthy People 2020, an HHS initiative that sets national public health objectives, is to reduce new cases of chronic kidney disease (CKD) and its complications, disability, death, and economic costs. The Healthy People 2020 objectives include increasing the proportion of persons with diabetes and chronic kidney disease who receive recommended medical evaluation and treatment, increasing cardiovascular care in persons with CKD, and reducing kidney failure due to diabetes.
 - In alignment with this aim, Department agencies have taken actions in a number of domains. For example, CDC is conducting pilot projects to increase screening for CKD and enhance surveillance systems to better assess the prevalence and incidence of CKD. Additionally, as required by the Medicare Improvements for Patients and Providers Act of 2008, CMS is establishing Medicare coverage of kidney disease education services for those with Stage IV CKD. Medicare now covers up to six sessions of kidney disease education, which has helped beneficiaries delay the need for a kidney transplant or dialysis and prevent kidney disease complications. Finally, CMS is expanding the CDC's National Diabetes Prevention Program. This is important because diabetes is the leading cause of end stage renal disease and a contributor to broader kidney disease and kidney failure.

- In addition to current activities, HHS is working to take the following additional steps to promote early detection and treatment such as developing and implementing efforts to reach high risk groups through other CDC and NIH prevention and education programs and working with the National Kidney Foundation and other organizations to establish or create Podcasts/YouTube videos/other online media describing the benefit of early detection and treatment for chronic kidney disease.
- b. Through reimbursement policy changes and new model tests, CMS is helping to detect and treat chronic kidney disease earlier.
- For example, beginning in 2015, Medicare now pays for care management separately under the Medicare Physician Fee Schedule by making a separate payment for chronic care management services delivered to patients with multiple chronic conditions, such as chronic kidney disease. These services include developing a plan of care to help manage chronic conditions, managing care transitions, and coordinating services with practitioner and providers.
 - Medicare also pays for specific transitional care management services provided during a beneficiary's transition to the community setting following particular kinds of discharges.
 - As part of the Department's efforts to deliver better care, spend dollars more wisely and have healthier people, HHS is working to improve the way doctors are paid to focus on paying for quality of care, over quantity of services, and keeping patients healthy. This type of whole person care has important ramifications for helping prevent and treat chronic diseases like kidney disease.
- c. Today, Medicare covers a variety of different chronic kidney disease services, but we recognize that we need to take additional steps to support the coordination of care within and around these services for Medicare patients given the incentives in the current Medicare fee for service system.
- Currently Medicare covers the following chronic kidney disease services:
 - **Kidney disease education:** Medicare Part B covers up to six sessions of kidney disease education for beneficiaries with Stage IV CKD to help delay the need for a kidney transplant or dialysis and prevent kidney disease complications.
 - **Inpatient dialysis treatments:** Medicare Part A covers dialysis for beneficiaries in a Medicare-approved hospital.
 - **Outpatient maintenance dialysis treatments:** Medicare Part B covers a variety of services for beneficiaries receiving routine maintenance dialysis from a Medicare-certified dialysis facility.
 - **Self-dialysis services:** Medicare Part B also covers a range of services for beneficiaries who are candidates for self-dialysis, including training conducted by a Medicare-certified dialysis facility, self-dialysis support services provided by the dialysis facility, and all kidney dialysis equipment and supplies for as long as dialysis is needed at home. In addition, Part B covers certain drugs (including heparin) for self-dialysis, as well as erythropoiesis-stimulating agents (ESAs) to treat anemia related to renal disease.

While Medicare providers can be paid for individual services and treatments around dialysis, this way of paying for services individually (fee-for service) can have the negative incentive of leading to more services but not necessarily better quality or better coordinated care, both of which are important for preventing and managing diseases like chronic kidney disease. That's why we're working to change how we pay doctors and health care systems, so they can focus on quality of care not quantity of services. The Affordable Care Act offers many tools to improve the way providers are paid to reward quality and value instead of quantity and to strengthen care delivery by better integrating and coordinating care for patients.

For example, the CMS Innovation Center is conducting a Comprehensive ESRD Care Model to identify, test and evaluate new ways to improve care for Medicare beneficiaries with End-Stage Renal Disease (ESRD). In the Comprehensive ESRD Care Model, dialysis clinics, nephrologists and other providers join together to create an ESRD Seamless Care Organization (ESCO) to coordinate care for matched beneficiaries. ESCOs are accountable for clinical quality outcomes and financial outcomes for their beneficiaries. This model encourages dialysis providers to think beyond their traditional roles in care delivery and supports them as they provide patient-centered care that will address beneficiaries' health needs, both in and outside of the dialysis clinic.

- d. Slowing the development of ESRD has important implications for our health care system. More than 600,000 Americans have ESRD and require life-sustaining dialysis treatments several times per week. In 2012, ESRD beneficiaries comprised 1.1% of the Medicare population and accounted for an estimated 5.6% of total Medicare spending, totaling over \$8.6 billion. These high costs are often the result of underlying disease complications and multiple co-morbidities, which can lead to high rates of hospital admission and readmissions, as well as a mortality rate that is much higher than for the general Medicare population. Slowing the rate of entry into the ESRD program through earlier detection and prevention can help keep beneficiaries healthier and help us spend our health care dollars more wisely.

Rovbal-Allard 7- Title VII Health Professions Programs and AHEC

The Title VII health professions training programs housed at the Health Resources and Services Administration are vital to the production of primary care health professionals that are committed to serving diverse and underserved throughout the country. I have been calling for their full funding during my entire tenure on the Subcommittee, and I want to commend the Administration for recommending \$25 million for the Minority Centers of Excellence program and \$14 million for a HCOP program, because it is critical that we focus our efforts on the beginning of the health professional pipeline—like COE and HCOP can provide—not just the end.

Unfortunately the Area Health Education Centers (AHEC) program, which supports the middle part of the pipeline, was not funded in the President's FY17 Budget. AHEC was repeatedly cited in the Congressional Justification for its successful ability to recruit, retain, and train a diverse and well-distributed primary care work force; and the program was lauded for often exceeding the agency's goals and objectives, including contracting with the Federal Government to take on new projects, such as health care exchange enrollment and mental behavioral health training for non-VA providers to service our veterans. Now we are also hearing that the Department is planning to make changes to the program that are not consistent with its authorization.

- a. Can you explain why a program which is exceeding your Department's expectations was not funded in FY17?
- b. What are the changes you are contemplating and what research can you cite as to why these changes are justified?

Response:

- a. While the Area Health Education Centers Program exposes medical students and health professions students to primary care and practice in rural and underserved communities, the FY 2017 President's Budget reflects the prioritization of funding to programs that directly increase the number of primary care providers like the National Health Service Corps.
- b. Ensuring an adequate supply of primary care providers for the future remains key to providing high-quality health care, especially in rural and underserved areas. According to data compiled by the HRSA Bureau of Health Workforce, approximately fifty million Americans live in rural or inner-city locations designated as health professional shortage areas for the purposes of primary medical care.¹² As projections indicate that the demand for primary care services over the next decade is expected to increase,¹³ it will be important to train a skilled workforce of primary care providers who are capable of serving diverse populations, particularly in underserved areas. These important findings inform the Administration's health workforce

¹² U.S. Health Resources and Services Administration, Bureau of Health Workforce, Designated Health Professional Shortage Areas Statistics, available at https://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry_.HTML&rc:Toolbar=false.

¹³ Peterson, S., Liaw, W., Phillips, R., Rabin, D., Meyers, D., & Bazemore, A. (2012). Projecting US Primary Care Physician. Annals of Family Medicine, 10(6), 503-509.

proposals for the FY 2017 President's Budget, which prioritize investments that directly increase the number of primary health care providers, as noted above.

Royal-Allard 8- Trauma Centers

Recent tragedies like the San Bernardino Health Department shooting and the Boston Marathon Bombing have highlighted the importance of the immediate availability of emergency medical personnel, and the timely access to major trauma and burn centers. But lack of trauma care access -- especially in rural areas -- is more often the reality in the United States. Unfortunately, 45 million Americans lack access to a Level I trauma center within that first "golden hour" that is essential to saving lives. And according to UCSF researchers, over the last two decades about one-third of the 1,125 trauma centers across the nation have closed.

- a. What are the challenges and opportunities to improve access to trauma care in underserved areas?
- b. What are the reasons that trauma centers close, and what can be done to address this looming access crisis in trauma care?

Response:

- a. Trauma and burn care are integral parts of the broader emergency care system and it is difficult to consider them in isolation. In 2007, the Institute of Medicine concluded that emergency care in the United States is "overburdened, underfunded, and highly-fragmented." In the decade since the release of that publication, many of these challenges have persisted. While some of the challenges facing trauma care are unique, they must be considered as an integral part of the emergency care system. Challenges and opportunities to improving access to trauma care in underserved areas include:
 - **Trauma Center Funding:** Trauma center funding has always been variable. In 1973, Congress enacted the EMS Systems Act that created a lead agency under the former Department of Health, Education, and Welfare and acknowledged 15 components, including one trauma system component, to aid system planners for area-wide or regional EMS programs and trauma planning. However, in 1981, the Omnibus Budget Reconciliation Act modified the federal allocation of EMS and trauma system funds into a state preventive health block grant program. Currently, the vast majority of fund for trauma center are fee for service reimbursements (including trauma activation fee, physician fees, etc.). Some states and local jurisdictions have developed separate funding streams for trauma centers and others depend on payers, providers, and facilities.
 - **Trauma Center Reimbursement:** Trauma centers are reimbursed for quantity of services instead of quality of services. Trauma care is a fee-for-service (FFS) that benefits facilities when there is more volume for their specific facility. This leads to hospitals focusing on either high margin or high frequency services as they are required to sustain operations.
 - **Trauma Center Designation:** Trauma centers are typically designated by state agencies based on guidelines created by the American College of Surgeons – Committee on Trauma (ACS-COT). The ACS first published guidelines in 1976 and continually updates and expands them,

most recently in 2015. Trauma centers must be regularly evaluated and re-certified by their respective credentialing bodies. States typically designate trauma centers and locations based on demand through a centralized planning model that is not risk-based.

- b. Operating a trauma center is a resource-intensive enterprise that comprises extensive finances, personnel expertise, supplies that are commensurate with the demand of incoming patients, and a high number of patients. Furthermore, trauma centers need to treat a high number of insured patients with traumatic injuries in order to sustain operations and to ensure clinicians' skills and abilities to treat traumatic injuries do not deteriorate.

Hospital systems generally locate trauma centers in such a way to ensure sufficient volume, not to ensure timely access to care. Also, trauma capacity is based primarily on day to day volume, not a risk based model. Trauma centers that treat a high quantity of uninsured patients with traumatic injuries are at risk for closure because the centers are unable to recover the high cost of providing such care. Recently we have seen cases of trauma centers ceasing operations, or moving to more favorable locations.

Roybal-Allard 9- Project Bioshield SRF

The Pandemic and All-Hazards Preparedness Reauthorization Act (P.L. 113-5) authorized \$2.8 billion in funding for the Project BioShield Special Reserve Fund (SRF) over five years (FY2014-FY2018) and last years' 5 year spend plan for BARDA detailed expected procurements of more than \$800 M for FY 2017. It is concerning that the President requested just \$350 million for the Special Reserve Fund for FY 2017 and that language was included in the President's Zika request would expand the allowable uses for the SRF –further stretching these funds.

- a. Do you believe that with this reduction in funds, the U.S. could still be prepared to respond to threats like Marburg, anthrax, a dirty bomb, pandemic influenza, or smallpox?
- b. As BARDA ramps up testing of treatments and vaccines for Ebola and now Zika, what impact are these outbreaks having on the development of countermeasures against all the other biological threats?
- c. Have you had to shift funding from other previously planned programs, or have development projects against other threats been shut down as a result? If so, how costly will it be to start them up again?

Response:

- a. The report on Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) estimates for spending in FY 2015 – FY 2019 are based on professional judgment on these programs. The report describes the importance of programs that address specified threats identified through the Material Threat Determination process used to set strategic requirements for medical products. Projected estimates are based on specific assumptions to maintain current preparedness efforts and projections are made without consideration of other competing priorities that are reflected in the formulation of the President's Budget.

Project BioShield is a shared national security priority. The FY 2017 President's Budget will enable us to make meaningful progress on vital medical countermeasure (MCM) procurements. Unlike a grant or research program that supports a steady and recurring level of effort, the Project BioShield budget is made up of a different set of discrete procurements in any given year when medical countermeasures are mature enough in development to meet Food and Drug Administration (FDA) requirements for accessibility under Emergency Use Authorization. In FY 2017, the new resources will enable the Department to procure small quantities of a few additional chemical, biological, radiological and nuclear (CBRN) MCMs sufficiently mature for procurement, including:

- New Ebola vaccines and immunotherapeutics for the prevention and treatment of Ebola infections;
- New high throughput biodosimetry devices to measure internal radiation exposure following a detonation;
- New antibiotics for the treatment of bacterial biothreats and high priority antimicrobial resistant bacteria;

- New diagnostics for the detection of anthrax in exposed persons; and
- Replenishment of anti-neutropenia cytokines for the treatment of radiation-induced blood illnesses.

The Office of the Assistant Secretary for Preparedness and Response (ASPR) and the PHEMCE are committed to maintaining our national preparedness and making sure that MCMs are available when needed. Maintaining stockpiles of MCMs typically entails large procurement costs and is associated with substantial carrying costs. In an era of constrained resources, the Biomedical Advanced Research and Development Authority (BARDA) within ASPR and its PHEMCE partners are mindful of the need to meet established requirements, sustain preparedness, and be good stewards of the taxpayers' investments. To this end, the PHEMCE is currently working to refresh the Material Threat Assessments that form the foundation for our requirements, many of which have not been reassessed in years. ASPR, for its part, emphasizes innovative approaches to total lifecycle cost-containment and strives to decrease the long-term costs of stockpiling MCMS.

One method is repurposing of commercial products and taking advantage of the commercial market, under vendor managed inventory (VMI). This method is currently being leveraged for cytokines to address neutropenia resulting from exposure to ionizing radiation.

Another method that ASPR is employing is stockpiling of bulk intermediates. Bulk products do not have expiry associated with them like final drug products and can be maintained for longer periods of time. Stockpiling of bulk intermediates also allows ASPR to cut manufacturing times if additional product is necessary for a larger event.

- b. There are always competing priorities for finite resources. ASPR/BARDA has evolved our strategy from lessons learned from responses to H1N1 and Ebola to invest, where possible, in platform technologies that can address chemical, biological, radiological and nuclear (CBRN) threats, pandemic influenza but may also be applicable to emerging and infectious diseases such as Zika. Sufficient supplemental funding was provided for the Ebola response and the recent resurgence of Ebola in Guinea highlights the need to complete the mission to develop effective vaccines, therapeutics and diagnostics against that threat.

An additional example for Zika is the investment in pathogen reduction technologies. These technologies were of interest to BARDA for the treatment of plasma and other blood products that would be necessary for a response to a nuclear incident. Investments in such technologies could maintain a safe blood supply even during future outbreaks of yet to be identified emerging and infectious diseases. Where possible, BARDA leverages previous or ongoing investments in technologies that have the ability to address multiple threats.

- c. As previously stated, there are always competing priorities for finite resources. BARDA would not "shut-down" a program to respond to another threat. Instead, there would be a need to potentially decrease funding for a period of time or procure a lower level of products with hopes of receiving additional funding in future fiscal years to make up for the temporary shortfall. BARDA has brought value to protecting the American people since 2004 and the Administration's seeks sufficient funds, under emergency supplemental appropriations, for

additional efforts to combat Zika. BARDA and the PHEMCE have become the benchmark for product development and have been identified as a model by international partners concerned about global pandemics and emerging diseases. BARDA has addressed, and will continue to address, CBRN threats and pandemic influenza. BARDA will also accept the challenge to address emerging and infectious disease outbreaks. However, appropriate funds will need to be provided in order for BARDA to make an impactful difference and ensure the safety of the American people.

Roybal-Allard 10- Pandemic Influenza

One of the most urgent public health threats we face as a nation is pandemic influenza. As you know, the 2009 H1N1 pandemic fortunately was a relatively mild pandemic, and killed only 18,000 Americans and sickened 600,000 more. Pandemic influenza is not just a public health threat, it is indeed a national security threat. Yet HHS' efforts to prepare for and respond to pandemic flu have been chronically underfunded, and I am disappointed that your 2017 budget request does not address this problem or request additional funding.

- a. Have you spent all available FY15 funds for pan flu? If not, how much is still available?
- b. What are you doing to ensure HHS sustains readiness efforts against this threat?

Response:

- a. Yes, all available FY 2015 funds for pandemic influenza have been obligated.
- b. BARDA is ensuring that critical countermeasures, including diagnostics, vaccines, antivirals, Personal Protective Equipment and other necessary healthcare products are available to mitigate the next influenza pandemic. BARDA is collaborating with PHEMCE partners to implement improved vaccine viruses and assays to accelerate the availability of vaccine and investing in the development of new vaccine approaches to improve vaccine efficacy and broad spectrum activity against a variety of circulating flu viruses.

Roybal-Allard 11- Strategic National Stockpile

As you know, BARDA and CDC need to coordinate efforts as MCM products transition from the advanced research and development phase to the approval phase, and stockpiling in the Strategic National Stockpile (SNS). I believe BARDA and CDC must do a better job working together to avoid any gaps or delays that could be created if the agencies have conflicting stockpiling priorities.

- a. What steps do you think BARDA and CDC could take to improve coordination of the SNS?
- b. How can you ensure we are maintaining adequate supplies of approved and purchased medical countermeasures?
- c. What resources are needed to replenish existing stockpiles and is the President's request sufficient to accomplish this?

Response:

- a. The Biomedical Advanced Research and Development Authority (BARDA) and the Centers for Disease Control and Prevention (CDC) currently participate in the Public Health Emergency Medical Countermeasures Enterprise (PHEMCE) to achieve this coordinated vision and action on medical countermeasures (MCMs) intended for the Strategic National Stockpile (SNS). The current PHEMCE governance process provides clear directives for stockpiling goals, including products developed by BARDA, some of which will be added to the SNS when there is enough data available to use the product under an Emergency Use Authorization (EUA) or Investigational New Drug (IND), or if the product is Food and Drug Administration-approved.

For each fiscal year, CDC receives clear prioritization and guidance from PHEMCE on the prioritization of capabilities and requirements for the SNS in the SNS Annual Review. The recommendations in this report provide the foundation for CDC procurement decisions and strategy for the SNS, and includes guidance on the BARDA developed countermeasures held in the SNS. Recent progress has been made in addressing the handoff of BARDA developed products, for which CDC assumes replacement responsibilities and costs at the end of the initial BARDA procurement.

- b. CDC works with PHEMCE to ensure that the MCM requirement process and subsequent stockpiling and procurement goals are appropriate. The PHEMCE governance process provides annual guidance to CDC on the prioritization of MCM procurement to ensure that SNS capabilities are aligned with the risk informed assessment of threats to U.S. populations. The PHEMCE guidance and recommendations minimize the risk to U.S. populations through the stockpiling of MCMs to protect individuals and communities from the most likely threats that they face. PHEMCE and CDC use current clinical practice, market availability, and the best application of public funds to guide acquisition targets and decisions. CDC monitors product expiration, replacement requirements, and changing commercial landscape, and incorporates that information into multiyear budgeting projections

as well as current year procurement plans. These projections and procurement plans are prioritized in alignment with the stockpiling goals recommended by PHEMCE and within the funding appropriated for the SNS.

- c. At the FY 2017 President's Budget level, CDC will replace the majority of expiring SNS MCMs, although changes in current projections for product replacement requirements and costs indicate CDC will not be able to maintain all current capabilities. Products held in the SNS for use against Anthrax and other biological threats, including anthrax vaccine and certain antibiotic products will be procured at a reduced level, as recommended in the 2014 SNS Annual Review Report. Level funding in FY 2017 will allow CDC to sustain most expiring SNS products through replacement. CDC will coordinate with PHEMCE to develop strategies to meet national priorities in the 2014 SNS Annual Review with available funding.

CDC collaborates with PHEMCE to prioritize and adjust the SNS holdings on current threats and funding. The FY 2017 Budget continues to support activities within CDC and NIH to support activities CE is responsible for defining and prioritizing requirements for public health emergency MCMs, as well as establishing deployment and use strategies for SNS products. Furthermore, CDC works with PHEMCE in developing a five-year budget plan, taking into consideration the requirements and costs of SNS products. CDC's five-year projections are also part of the SNS Annual Review process to identify projected funding shortfalls or available funding for new procurement in future fiscal years, which lead to PHEMCE recommendations for CDC procurement strategy as reported in the SNS Annual Review Report. Should SNS be unable to maintain current preparedness capabilities in FY 2017 due to changes in expiration projections or PHEMCE requirements, PHEMCE recommends that CDC reduce the planned procurement of anthrax vaccine and suspend procurement of certain formulations of antibiotics to address the difference.

TUESDAY, MARCH 1, 2016.

BUDGET HEARING—CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

WITNESS

WENDY SPENCER, CHIEF EXECUTIVE OFFICER, CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

INTRODUCTIION OF WITNESS

Mr. COLE. I will go ahead and convene us, and I will get to my opening statement, but before I do, as we were discussing, Ms. Spencer, in the back, it has been 16 years since this committee has had the opportunity to hear about some of the wonderful things you are doing at the Corporation for National and Community Service, but it hadn't been 16 years since any of us have seen you. We see you regularly around the country and across our districts, and so I appreciate very much the manner in which you run your agency, and frankly, how accessible you have been to every member of this committee, quite frankly. So it is a genuine pleasure to have you here.

Good morning. Again, my pleasure to present Ms. Wendy Spencer, the CEO of the Corporation for National and Community Service to the Subcommittee on Labor, HHS, and Education to discuss the agency's fiscal year 2017 budget request.

We are looking forward to hearing your testimony, especially since it has been quite a while since this subcommittee has held a hearing on the Corporation's budget. We tried to have you up last year, but unfortunately, we had to cancel because of conflicting schedules. So we are very happy that you are able to be here today and join us.

America has a long and rich history of service and volunteerism. About one in four Americans formally volunteered with an organization in 2014, contributing in ways ranging from tutoring to preparing meals for the homeless to assisting their neighbors in the wake of natural disasters.

The Corporation's programs support, enhance, and expand upon these efforts through helping to build capacity at the State and local level and by awarding grants to place volunteers where they are needed across the country. Both the Corporation and Congress have a responsibility to conduct oversight of the Corporation's approximately \$1,000,000,000 in budget authority to ensure that taxpayer funds are being spent wisely. We look forward to hearing about the Corporation's accomplishments over the past years and plans for the upcoming fiscal year.

As a reminder to the subcommittee and our witnesses, we will abide by the 5-minute rule so that everyone will have a chance, but

we may be a little more generous on the 5-minute rule than normal. So anyway, again, we are very anxious to have you here.

And with that, I would like to yield now to my ranking member, the gentlelady from Connecticut, for her opening remarks.

Ms. DELAUR. Thank you so much, Mr. Chairman. And my apologies for being late, but great to be here. And as I said, listen, if it is the two of us, it is the two of us. Why not, you know? So here we go.

I want to say thank you for holding the hearing because I think we share the view that the programs we speak of this morning tap into one of the best attributes that we have as a nation. National service is a core American value. It makes this country exceptional. Service provides an unparalleled richness for those that participate and gives citizens the greatest potential to change the face of the communities that they serve.

So I welcome you, Ms. Spencer. I look forward to talking with you. And yes, it has been 16 years, and we know we tried last year, so delighted you are here today. But fortunately, your work over these years has demonstrated how valuable these efforts are.

The Corporation for National and Community Service was founded on the idea that government can and should play a role in giving citizens the opportunity to address pressing problems across the country. It is a powerful idea that carries on despite whatever happens in this institution on both sides of the aisle.

Last year, we were able to make important investments in the Labor, HHS bill, including a small, much-needed increase for the Corporation. We provided an additional \$50,000,000 for AmeriCorps, an additional \$10,000,000 for the National Service Trust. We supported an increase of more than 10,000 new AmeriCorps members to serve and created new opportunities in communities across the country. And in many ways, last year's omnibus moved the Federal budget in the right direction.

The chairman has heard me say this last week, and he will continue to hear me say this. With Labor, HHS, we received a fraction of what I believe is our fair share last year of the \$66,000,000,000 increase that was provided by the budget deal. Other nondefense subcommittees received an average increase of 6.9 percent. Labor H was about 3.4 percent. And we do have 32 percent of the non-defense discretionary budget.

So the issue for me is how we continue to try to move in a direction that allows us to get increased resources in order to meet the needs, your needs and our needs. Because if we take a look at what happened last year and we reversed it, we had a House mark that slashed the Corporation's funding by \$367,000,000. It was a cut of 35 percent. And that would have really decimated programs that serve millions of our most vulnerable citizens. And fortunately, really, and I mean that very sincerely because it was hard-fought to get an agreement and to avoid what were harmful cuts.

So again, it is the richness of the experience that these programs provide. It makes young people really become engaged in the fabric of our society so they are not little islands by themselves, but they understand that they have a responsibility, that they are not out there for himself or herself, that we share a responsibility for what

happens in our country. And that helps us to move the needle on the great issues of the day.

Volunteers today are preserving our parks, our public lands, mentoring our students, providing job training for veterans, responding to national disasters, and as I said, supporting our most vulnerable citizens.

Communities want programs like AmeriCorps. In 2015, CNCS was only able to fund a third of all grant applications that it received. Last week in our hearing with Secretary Burwell, we talked about the tragic situation in Flint. Thousands of children have been exposed to lead-poisoned water for more than a year. Your folks have responded to this crisis working with Michigan agencies, nonprofit organizations for the past few months to address the crisis. They are boots on the ground. They are there. Nine members of AmeriCorps National Civilian Community Corps are on the ground in Flint. They are going door to door. They are trying to educate residents on using water filters appropriately, providing information on nutrition related to lead exposure. I am going to be in Flint on Friday, and I would love to talk with you about trying to get to meet some of your folks there.

Senior Corps volunteers and other CNCS member volunteers are assisting in public education, providing bottled water, managing donations, helping to process hundreds of non-CNCS volunteers, placing them where they are most needed. This is why our investment here is essential. You connect volunteers to communities in their hour of need.

I am pleased in the budget to see a request for a modest increase to the VISTA programs, an additional 230 full-time VISTA members who commit to serve for a year in some of our most impoverished communities. I am disappointed to see level funding for the National Senior Volunteer Corps and that the budget request is more than \$50,000,000 below the agency's budget. As I have said, this is a smart investment in these programs. You help Americans graduate. You help people pursue higher education and find work.

So, again, every dollar invested in national service results in a return to society of nearly \$4 in terms of higher earnings. I will repeat something that I have said, and that is these programs are so important, and that is why I will continue to fight for a higher allocation for this subcommittee for the good of the communities who depend on us.

Thank you so much, and we look forward to your participation and your discussion. Thank you, Mr. Chairman.

Mr. COLE. Before we move to you, I know my friend from Connecticut will know that while I appreciate her efforts, I am always happy to see level funding because that is probably what I am going to get. So I am very grateful that you have come in the door that way. That is a good start. [Laughter.]

Mr. COLE. But with that, if we may, Ms. Spencer, let's turn to you for your opening remarks and then we will move to questions and answers from the committee and obviously from yourself.

WITNESS OPENING STATEMENT

Ms. SPENCER. Thank you so much, Chairman Cole and Ranking Member DeLauro, Congresswoman Lee. It is really great to be here, and this is a wonderful opportunity for us to testify.

We are grateful for the funding increase Congress provided last year to support our vital work. And I want that to be noted. We are very grateful and very appreciative.

Our 2017 budget request is \$1,100,000,000, which is almost level funded, as you mentioned, from last year. This budget will support our mission to improve lives, expand opportunity, and tackle some of the Nation's most important needs.

Allow me to describe some of our work to you. First, we empower citizens to solve problems. Senior Corps and AmeriCorps members serve at more than 50,000 locations across the country. These dedicated Americans serve in tough conditions to meet local needs like tutoring and mentoring youth, eliminating hunger, responding to disasters, supporting veterans and their family members, just to name a few, all while recruiting millions of Americans to serve alongside them, multiplying the impact.

Second, we leverage substantial outside resources. I am very pleased to share with you today that for the first time in our agency's history we were able to report that our local support has exceeded our Federal appropriation, a goal of mine since I started 4 years ago. Last year, our programs generated \$1,260,000,000 in required match, additional resources from corporations, foundations, local community organizations, and also resources raised by our members. This local support boosts our impact and stretches the return on the taxpayer dollar, so I am very, very proud of this announcement, which we have just been able to make.

Third, we really recognize and support local control. Governors play a very key role in deciding where AmeriCorps resources go through State service commissions, as an example. Local groups recruit, select, and supervise their members. This is done at the local level. Mayors and county leaders also see us as a key partner. In fact, last year, just shy of 2,800 mayors and local leaders and tribal leaders representing 150 million Americans united to recognize AmeriCorps and Senior Corps on a single day.

And fourth, we expand opportunity in so many ways like keeping students on track to graduate, housing homeless veterans, helping seniors live independently, and connecting people to jobs. Plus, AmeriCorps members provide valuable skills and scholarships to help themselves. These scholarships pay back college and student loans or help them go to college for the first time. It is a great benefit if you want to serve and you can receive a benefit to increase your higher education goals.

Our 2017 budget builds on this foundation to meet community needs with greater impact, accountability, and efficiency. Our budget request supports the following: 88,400 AmeriCorps members serving in programs that depend on their skills and their leadership, programs like Habitat for Humanity, Teach For America, City Year, Catholic Charities, Veteran Corps, conservation corps, and in tribal communities. It also supports 270,000 older Ameri-

cans in Senior Corps programs while introducing competition to Foster Grandparents and Senior Companion.

It will help support evidence-based programs through our Social Innovation Fund, including our Pay for Success pilot. And it will support investments in our IT systems to increase accountability, efficiency, and provide first-rate support to our grantees and partners, something we need and it is overdue.

So, Mr. Chairman and members of the committee, our programs empower citizens. They bolster civil society, expand opportunity, encourage personal responsibility, strengthen our communities, and I contend they unite us as Americans.

Thank you for your support. Thank you for inviting me today. It is a true honor to serve in this role to help engage Americans in service and help support our local organizations. I am happy to answer your questions. And as always, I seek your guidance and advice. Thank you.

[The prepared statement and biography of Wendy Spencer follows:]



**Testimony of Wendy Spencer
Chief Executive Officer
Corporation for National and Community Service**

Before the

**Subcommittee on Labor, Health and Human Services, Education, and Related Agencies
Committee on Appropriations
United States House of Representatives**

**Hearing on the President's Fiscal Year 2017 Budget Request
March 1, 2016**

Chairman Cole, Ranking Member DeLauro, and Distinguished Members of the Subcommittee,

Thank you for inviting me to testify on the Administration's fiscal year (FY) 2017 Budget request for the Corporation for National and Community Service (CNCS). I appreciate this opportunity to tell you about our vital work to improve lives, expand economic opportunity, and engage millions of Americans in service to meet pressing local and national challenges.

We are grateful for the funding increase Congress provided in FY 2016 to support our mission. With the resources entrusted to us, we will continue to be responsible stewards of taxpayer dollars by investing in high-quality programs, leveraging outside resources, and delivering results on some of America's toughest problems.

Working hand in hand with thousands of local partners, our programs empower citizens to solve problems. They bolster the institutions of civil society. They expand opportunity through hard work and personal responsibility. They strengthen our communities. And they unite us as a nation.

The FY 2017 Budget continues this smart approach. Through targeted investments, our AmeriCorps, Senior Corps, and Social Innovation Fund programs will tackle pressing challenges – helping students graduate, rebuilding communities after disasters, supporting veterans and military families, increasing economic opportunity, preserving the environment, and creating healthy futures.

As CEO, I am privileged to work every day with a talented team at CNCS; extraordinary, mission-driven leaders in our field; and passionate, committed individuals who serve in our programs. Here are a few I have met:

- Within hours after a devastating tornado struck Moore, Oklahoma in May 2013, AmeriCorps and Senior Corps were on the scene. AmeriCorps teams, including from AmeriCorps National Civilian Community Corps and its FEMA Corps unit, conducted damage assessments, managed volunteers and donations, and provided legal assistance and client casework. Senior Corps RSVP volunteers answered disaster hotlines, served food at shelters, and assisted survivors. When I was there shortly after the tornadoes, I saw nearly 200 Senior Corps and AmeriCorps members providing vital support to survivors. In the first two months, they collected and distributed 265 tons of donations, conducted 651 damage assessments, and mobilized nearly 3,000 volunteers. Today, an AmeriCorps NCCC team is in Moore serving with Oklahoma United Methodist Church Disaster Response, mucking and gutting homes affected by Memorial Day flooding.
- Michelle Whitlock, whose grandfather started working in a coal mine when he was 14, joined AmeriCorps VISTA to support Shaping Our Appalachian Region (SOAR), an initiative launched by Chairman Hal Rogers and Governor Steve Beshear to improve the economy and quality of life in Eastern Kentucky after a severe downturn in the coal market. Michelle and 80 other full-time AmeriCorps VISTA members have made a powerful impact by serving with their partners to connect approximately 6,000 people with health and nutrition services, increase educational opportunities for more than 10,000 students, and connect more than 5,000 adults with employment services, including training unemployed coal miners to become computer coders. Michelle was instrumental in working with partners to secure a multi-million dollar grant to the Eastern Kentucky Concentrated Employment Program to help low-income residents get the education, training, and support they need to achieve self-sufficiency.

- Chrysalis, a Los Angeles nonprofit supported by our Social Innovation Fund grantee REDF, creates pathways to self-sufficiency for homeless and low-income individuals. It operates an evidence-based social enterprise program that provides transitional jobs to adults facing employment barriers. Chrysalis helps people like Eric gain skills to re-enter the job market. Eric spent 15 years living on Skid Row, going in and out of jail, struggling with substance abuse. In 2013, he knew he had to change. He tried for months to find a job, but with his background, no one would hire him. Then he found transitional employment at Chrysalis. Now Eric is off the streets, off drugs, and employed full-time. A recent evaluation found that, one year after accepting a social enterprise job through organizations such as Chrysalis, workers' average monthly income increased by 91 percent while their income from government benefits dropped from 71 percent to 24 percent.¹
- Elizabeth Oliver joined AmeriCorps VISTA after learning about the plight of homeless veterans as a college student. At age 20, she moved to Salt Lake City to begin a year of full-time service with The Road Home, Utah's largest homeless shelter. Elizabeth worked with the mayor's office to identify homeless veterans and recruit landlords who were willing to house them. Her efforts contributed to 97 homeless veterans gaining housing, helping Salt Lake City become one of the first cities to end chronic veterans' homelessness.

CNCS CORE PRINCIPLES

These stories happen every day and are made possible by the funding provided by Congress and local communities. They illustrate our focus on a set of smart, common-sense principles:

- **Empowering Citizens and Organizations to Solve Problems:** Our agency was created on a fundamental idea – to harness the ingenuity and can-do spirit of our people to solve local problems. AmeriCorps members and Senior Corps volunteers are dedicated citizens who work hard in tough conditions. They make an intensive, sustained commitment. They take on complex assignments, assume leadership roles, recruit and manage volunteers, and deliver powerful results. They serve at more than 50,000 locations – schools, food banks, homeless shelters, youth centers, and veteran's facilities – helping existing nonprofit and faith-based organizations expand their reach and impact through direct service and by mobilizing millions of additional volunteers. In addition, our Social Innovation Fund addresses longstanding issues like chronic unemployment, systemic homelessness, and unmet mental health needs by leveraging substantial non-federal support to grow evidence-based programs that improve lives and build the economic independence of low-income individuals.
- **Leveraging Resources Through Public-Private Partnerships:** Last year CNCS programs generated more than \$1.26 billion in outside resources from businesses, foundations, public agencies, and other sources. This means that leveraged resources exceeded our federal appropriation. Some of the nation's largest companies invest in national service programs including Google, Walmart, Target, Comcast, Bank of America, Cisco, Microsoft, CSX, and Home Depot – along with thousands of small businesses, community foundations, and local agencies. This local investment strengthens community impact, increases the return on taxpayer dollars, and demonstrates great confidence in our programs' abilities to deliver results on some of America's most pressing problems.

¹ Rotz, D.; Maxwell, N.; Dunn, A. (2015) Economic Self-Sufficiency And Life Stability One Year After Starting A Social Enterprise Job. Mathematica Policy Research: San Francisco, CA.

- **Supporting Local Control and Community Solutions:** National service invests in local community solutions. Our support strengthens - not displaces - the work of existing civic, neighborhood, and community groups. Governors play a key role in deciding where national service resources go, with three-fourths of AmeriCorps funding overseen by Governor-appointed State Service Commissions. Local organizations selected for our funding are responsible for recruiting, selecting, and supervising their participants. We work closely with city, county, and tribal officials to identify local needs and deploy our resources to meet them. For example, last year we increased our grants to tribal organizations by 29 percent – our largest investment in the past decade. Local leaders see national service as an important partner in solving problems, as shown by the participation of 2,786 mayors and county leaders representing 150 million Americans in last April's Mayor and County Recognition Day for National Service². Additionally, our Social Innovation Fund supports more than 300 organizations serving nearly 600,000 people in 35 states by investing in their interventions, building their evidence base, and helping them scale with matching funds, often from local philanthropy.
- **Expanding Economic Opportunity:** By helping seniors live independently, keeping students on track to graduate, and connecting returning veterans to jobs, our programs increase economic independence and build family stability. National service is also a pathway to education and employment for those who serve. Since 1994, nearly one million AmeriCorps members have earned \$3.1 billion in education awards to reduce student loan debt or pay for college. As part of their service, many AmeriCorps members receive certifications such as First Aid, CPR, teaching, and disaster response. They also gain valuable skills including leadership, management, and problem-solving that all employers look for. In recognition of these skills, more than 300 organizations with 1.4 million employees have become Employers of National Service, committing to recruit AmeriCorps and Peace Corps alumni into their workforce. These employers - including Disney, Comcast-NBCUniversal, Sodexo, CSX, NASA, Omni Air International, the Idaho Food Bank, the states of Montana and Virginia, and Nashville, Philadelphia and New York City - know that AmeriCorps alumni are dedicated, talented, and mission-driven; and want more of them on their teams.

2017 BUDGET PRIORITIES

The President's FY 2017 Budget builds on these core principles and our decades of experience in engaging citizens in national service, social innovation, and volunteerism. The request of \$1.1 billion – virtually level with FY 2016 – will support CNCS and its thousands of state and local partners in meeting community needs with higher levels of impact, evidence, accountability, and efficiency.

Within our Budget, we have three key priorities: increasing community impact; funding what works using evidence, competition and innovation; and ensuring accountability and efficiency.

INCREASE COMMUNITY IMPACT

The first priority is to increase our impact on the priorities Congress identified in the Serve America Act: disaster services, economic opportunity, education, environmental stewardship, healthy futures, and veterans and military families.

² <http://www.nationalservice.gov/special-initiatives/mayor-and-county-recognition-day>

- The Budget supports an estimated 88,400 AmeriCorps positions – including 1,000 FEMA Corps members – to serve through nonprofits such as Habitat for Humanity, City Year, and Teach For America to address critical community challenges, from disaster response and homelessness to hunger and low-performing schools. It proposes an opportunity for up to 8,000 disconnected youth to serve as AmeriCorps members during the summer, giving them an opportunity to serve their communities while exploring potential career paths, developing skills, and earning an education award they can use for college.
- The Budget expands Resilience AmeriCorps, our partnership initially launched with Cities of Service, the Rockefeller Foundation, the National Oceanic and Atmospheric Administration, and other federal agencies. The Budget would support roughly 175 additional AmeriCorps VISTA members to help tribal, state, city, county, and nonprofit leaders plan for and support their communities as they become more resilient to the impacts of extreme weather and natural disasters.
- The Budget supports 270,000 older Americans to serve in Senior Corps programs as Foster Grandparents, Senior Companions, and RSVP volunteers, tapping the wisdom and experience of older Americans to solve community problems. It also provides resources to strengthen the Nation's volunteer sector, supports the vital work of Governor-appointed State Service Commissions, and builds the capacity of organizations to recruit and retain volunteers to address critical community needs.
- The Budget also provides \$50 million to continue to support families and individuals in low-income communities through the Social Innovation Fund. This critical investment funds the growth of evidence-based interventions to promote economic opportunity, youth development, and healthy futures.

FUNDING WHAT WORKS USING EVIDENCE, COMPETITION, AND INNOVATIVE MODELS

Our second priority is maximizing the return on public investments by increasing competition; using evidence in budget, management, and grantmaking decisions; and supporting innovative models that allow communities to use taxpayer dollars only when outcomes are achieved.

Using Evidence to Drive Impact: CNCS operates two competitive grant programs that explicitly incorporate demonstrated evidence of effectiveness into funding decisions. These programs – AmeriCorps State and National and the Social Innovation Fund – together account for the largest share of CNCS program funding. The 2017 Budget will continue the focus of these programs on competitive grantmaking that prioritizes evidence-based models. All interventions funded through the Social Innovation Fund must be able to demonstrate at least a preliminary level of effectiveness then take part in a rigorous evaluation to either strengthen the evidence base for the intervention or to verify its effectiveness through a Pay for Success project.

The Budget proposes an increase in our evaluation account in order to build the capacity of grantees to use evidence and evaluation to strengthen outcomes, disseminate effective practices, and strengthen performance reporting. Funding will also support research on programs, such as the recent study of the Minnesota Reading Corps, AmeriCorps' largest tutoring program. This rigorous two-part evaluation, conducted by NORC at the University of Chicago³, provided compelling evidence that students tutored by AmeriCorps members achieved

³ Markovitz, C.; Hernandez, M.; Hedberg, E.; Silbergliit, B. (2014). Impact Evaluation of the Minnesota Reading Corps K-3 Program. NORC at the University of Chicago: Chicago, IL.

significantly higher literacy levels than students without such tutors. For example, kindergarten students with an AmeriCorps tutor produced more than twice as many correct letter sounds as those without one, a key measure of emergent literacy skills. The study also found that the impacts were statistically significant even among students at higher risk for academic failure and that the model was highly replicable.

Increasing Competition in Senior Corps: The Budget advances the adoption of evidence-based models by introducing competition into the Foster Grandparent and Senior Companion Programs and enhancing competition in the RSVP program. Competition increases the impact of federal appropriations by awarding grants to the highest quality grantees. In turn, competition encourages innovation, increases efficiency, and produces greater outcomes for both service participants and recipients. CNCS will provide technical assistance to current grantees to prepare for this change, as we did during the successful introduction of competition into RSVP.

Reserving the Taxpayer Dollar for Positive Outcomes: The Budget continues to allow up to 20 percent of Social Innovation Fund dollars to support Pay for Success projects. These projects can leverage philanthropic and private dollars to fund services up front, with government paying only after results occur, ensuring taxpayer dollars pay for results, not just the promise of results. We are committed to continuing this approach and helping other federal agencies learn from our work and explore how they might also apply this model.

ENSURING ACCOUNTABILITY AND INCREASING EFFICIENCY

An overarching priority across all of our work is ensuring accountability and increasing efficiency in our program and financial operations. The strong stewardship of federal funds is a top priority for me in everything that we do. We have built a culture of accountability among our staff and grantees, and we are continuously improving our risk management, internal controls, and oversight and monitoring.

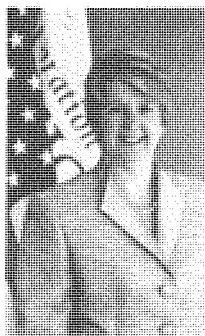
This Budget makes investments in those key areas, plus supports modernizing our information technology systems to enhance security and expand our enterprise-wide approach to risk management. These investments will drive accountability and increase efficiency so we can continue to maximize the impact of our federal funding and provide first-rate support to members, grantees, and the public.

CONCLUSION

Mr. Chairman, service and social innovation are a vital part of the American character. For decades, successive Administrations of both parties have invested in national service to tap the ingenuity and can-do spirit of the American people. The 2017 Budget continues this smart and cost-effective approach of engaging millions of Americans in solving local problems.

Thank you again for your support of our vital work and for inviting me to testify today. I am happy to answer your questions.

**Wendy Spencer
Chief Executive Officer
Corporation for National and Community Service**



Wendy Spencer was nominated by President Obama and unanimously confirmed by the U.S. Senate to serve as Chief Executive Officer of the Corporation for National and Community Service (CNCS) in 2012.

CNCS is a federal agency that annually engages 75,000 AmeriCorps members, 270,000 Senior Corps volunteers, and millions of citizens in results-driven service to solve local problems at more than 50,000 locations across the country. CNCS also strengthens the nation's volunteer sector through the Volunteer Generation Fund and Governor-appointed State Service Commissions, and invests in evidence-based community solutions that expand opportunity for low-income individuals through the Social Innovation Fund.

Under Spencer's leadership, CNCS has launched new partnerships, including FEMA Corps, School Turnaround AmeriCorps, STEM AmeriCorps, and Financial Opportunity Corps; increased the agency's focus on veterans and military families; expanded support for Native American communities, and overseen the national service response for many severe disasters.

Her efforts to engage elected officials include creating the annual Mayor, County, and Tribal Recognition Day for National Service, where last year 2,786 bipartisan mayors and county officials representing more than 150 million Americans expressed their appreciation for Senior Corps, AmeriCorps, and volunteerism.

Spencer's management career spans 32 years and includes leadership roles in the government, nonprofit, and private sectors. She has served in both Republican and Democratic administrations. Prior to coming to Washington, D.C., she served as the CEO of the Florida Governor's Commission on Volunteerism under Governors Jeb Bush, Charlie Crist, and Rick Scott. In this capacity, she connected national service and volunteer strategies to meet state prioritized needs and coordinated volunteer efforts in response to disasters, including eight record-breaking storms in 2004-2005. She also served as the Director of the Florida Park Service, where she oversaw natural resource and recreational management for 158 state parks spanning 600,000 acres.

Other organizations Spencer has served professional roles in include United Way, Chamber of Commerce, banking, insurance, industry, and legislative. Among other honors, Spencer has been named as a NonProfit Times Top 50 Leader and received the prestigious Governor's Award for her disaster work.

To learn about new initiatives and national service opportunities, visit NationalService.gov or follow @WendyCNCS on Twitter.

SOCIAL INNOVATION FUND

Mr. COLE. Thank you very much for your testimony. If we can, I want to have a couple of questions that will focus around the Social Innovation Fund in particular. In your budget justification, you mentioned several examples of positive outcomes that stem from efforts supported by the Social Innovation Fund such as improving employment retention for individuals that participate in job-training programs and increasing reading proficiency among K to 12 students. However, the process and criteria by which grantees and especially the sub-grantees are chosen in this program is a little unclear to me. So would you just elaborate about how you go about making the decisions on grantees and sub-grantees?

Ms. SPENCER. Thank you for that question. So the Social Innovation Fund is something we are very proud of. It is one of our newer programs in our 21-year history. We have been working on this for 6 years now, so it is a new program. And we are always looking for ways to improve it. But what I like most about the Social Innovation Fund, two things. One, it really does a deep dive on some of our nation's most difficult problems, addressing chronic homelessness, chronic unemployment, third-grade reading level for our students. So it really goes after some of the toughest problems with a surge of investment both at the Federal level and even more so at the local level.

The financial match for this program is really rigorous. It is almost three to one. The minimum grants are \$1,000,000 to the intermediary. It has to be matched by cash, dollar for dollar. And then when that intermediary is selected, they then have to subgrant out their grants in \$100,000 minimum increments and that has to be matched at the local level dollar for dollar.

So it is a very, very significant investment from the private sector. In fact, over the last 6 years, the Federal investment is about \$270,000,000, and the local investment is exceeding \$580,000,000. Now, let me just make this, you know, to a personal one, a couple that I visited, and I really like this example.

REDF is a program that focuses on chronic homelessness and unemployment. One of the sub-grantees is called Chrysalis. And I went in and met some individuals who have been unemployed and homeless virtually all of their adult lives, grown men in their 40s and 50s. And for the first time in their lives, they now have housing and a job, and the way they have it is the Chrysalis organization worked closely with them to provide a job through what they call a social enterprise. They have pest control services, they do corporate cleaning, they do wonderful training in addition to this.

And the one gentleman that I met who had been virtually homeless his entire life, he said this is the first time that I have had a job that I feel confident in and that I can do. One was working in pest control services, something that he could train for easily and be on time for and be prepared for. And the other gentleman is now driving a garbage truck for the local county.

So how do we get there? We get there through a rigorous competition. We had great interest in our applications. But it is difficult because you have got to have so much match from the local

level, and it is hard for intermediaries to do that, especially when we started, which was right in the beginning of the recession.

But one of the things that I asked these intermediaries, I said how have we been able to scale your program? And they said the thing about partnering with the Federal Government is that this was a seal of approval. We were able to get to the table new funders for the first time from foundations in the private sector because we were qualified to meet your rigor. We were also able to increase existing investments from organizations and foundations that we haven't been able to do in the past. So that is what they have told me, and it has been consistent.

So I do believe the process is very rigorous, but I always welcome improvements. It is new to us, so we are always trying to grow.

Mr. COLE. Thank you. I will have some other questions, but in the interest of time, let me go to the gentlelady from Connecticut for her opening questions.

EARLY CHILDHOOD EDUCATION

Ms. DELAURO. Thank you very much, Mr. Chairman.

And I would just say I think that we helped to restore funds in that program last year, and I think the explanation that Ms. Spencer has given us about the value of the program moves us in the direction of looking at really public investment and private investment and making it work. And that is a goal that we really all have here.

Let me ask about early childhood education and your work. Six million kids ages 5 and younger living in poverty in the United States. Deficits lower-income kids face during early years leads to unbelievable struggles later with academics, behavior, absenteeism. Between birth and age 6, children from more affluent families will have spent as many as 1,300 more hours than poor children on child enrichment activities, music lessons, travel, summer camp. Without early learning, low-income kids enter kindergarten as much as 60 percent behind their more affluent peers, and that gap just persists through adulthood.

In your testimony, you referred to the support that CNCS provides to schools through tutoring and mentoring programs. I am particularly interested in programs that support our youngest kids who are living in poverty. What early childhood programs do you all partner with? What percentage of your resources go to these programs? Is there a waiting list of early childhood programs that would like to work with you? And is there more you could do if you have additional resources?

Ms. SPENCER. Thank you so much for that question. This is an area that I am very passionate about. And let me tell you our footprint so you have a real clear picture, as you asked. We have six areas that we focus on: environment, education, economic opportunities, disasters, veterans and military families, and healthy futures. We could legitimately make a case to you to divide our funding six ways because those are all very important areas. But we have decided not to do that. Half of our budget and half of our resources are focused on education. And I do contend that many of those other problems in the other areas can be supported through

education and having a better-educated America as well. So it is very important that we are focused on this.

Our footprint is we looked and we counted between our Senior Corps, AmeriCorps and the Social Innovation Fund. We are serving of at least unduplicated grant and resources in 11,714 schools. That is huge. With 100,000 public schools in America, that is right at 10 percent. Of those schools that we are serving in, one in four of those are persistently low-achieving schools. So I feel like we have got them in the right places.

Now, early childhood examples, one of my favorites is the Minnesota Reading Corps. We did a rigorous third-party evaluation recently on the Minnesota Reading Corps, which was started in Minnesota and now is in 12 States, including DC, so it is being replicated, which is another passion of mine. Let's find what works and let's replicate it across the country.

Here is what it told us: This program is enrolling full-time AmeriCorps members as tutors, full-time, key word. They are tutoring in schools everything from preschool, kindergarten, first, second, and third grade. This study was really focused on kindergarten and early childhood, and here is what the study told us, that those students who had the access to the training and tutoring by the AmeriCorps members, the Minnesota Reading Corps AmeriCorps members, outperformed students that did not have access to AmeriCorps tutors, almost twice as much. And they outperformed in all five literacy testing areas that they looked at, all five. So this showed us that it is working. And I was so happy to be able to provide this evaluation, which I am happy to provide to you and your staff—

Ms. DELAURO. Yes.

Ms. SPENCER [continuing]. In full. But that tells us we are doing the right thing. And we have learned over the years that education really is the sweet spot for service. It is a great way for us to increase volunteerism as well. And I serve as a volunteer each week in an AmeriCorps program myself, and it is a curriculum-based program. It is not just I walk in and read to a student. I work through a curriculum. So it is working and we are focused on it.

Ms. DELAURO. Thank you. Do you deal with the HIPPY program, the Home Instruction for Parents of Preschool Youngsters program?

Ms. SPENCER. I feel that we do, but I can get back to you more but—

Ms. DELAURO. Please do because, Mr. Chairman, let me just tell you, my stepdaughter, who is now married with two children, she came home after she finished, you know, and she was in school and she said after college she was going to get a job and she was going to go work for the HIPPY program. Well, Stan and I were not quite sure what she was really going to do at that juncture—

[Laughter.]

Ms. DELAURO [continuing]. But it is the Home Instruction for Parents of Preschool Youngsters. This is working with parents and their children and using parents as a vehicle for reading and for their kids being able to be literate, and it follows a very strong curriculum, et cetera, to move forward on so—

Ms. SPENCER. Right.

Ms. DELAUBRO [continuing]. A good investment. Thank you very much.

Ms. SPENCER. Thank you.

Mr. COLE. You may have dated all of us who laughed so—

Ms. DELAUBRO. Right, exactly.

Mr. COLE. All right, good. We will go to my friend from California, the gentlelady, Ms. Lee.

COMPUTER SCIENCE AND TECHNOLOGY TRAINING

Ms. LEE. Thank you very much, Mr. Chairman.

First, welcome, and thank you very much for your testimony and for your service.

Programs like AmeriCorps VISTA, I mean, the taxpayer gets a heck of a lot for our investment, and I, too, believe we need to increase the budget, flat funding, fine, but for what you do and for what these volunteers do, we are saving a lot of money and providing real pathways out of poverty at a very cost-effective rate.

And so I think overall our committee is still 10 percent below pre-sequestration levels, so of course I join with our ranking member in wanting to see more funding for your very important agency.

A couple of things just as related to my district and how I know AmeriCorps VISTA, and what you are doing, the Reading Partners, you partner with local districts. And in my area, Oakland, Berkeley, San Leandro, you all help, the volunteers help lifelong readers, you provide critical one-on-one tutoring, and really ensure that children receive the literacy skills that they need to reach their fullest potential. It is still mind-boggling to think we have a literacy problem in America. And so what your volunteers are doing really makes it very clear what the benefits are by enrolling them in Reading Partners. It doubled their rates of learning, I know, in my district.

I chair the Congressional Black Caucus's Tech 2020 Initiative, which is an initiative to ensure that all Americans, including African Americans and people of color, are included in the levels of technology that we see booming in our country. And we are way under in terms of parity in the tech field.

So I am pleased to see that the President's budget includes \$135,000,000 in existing funds under the STEM AmeriCorps program, which is in partnership with the National Science Foundation, to help teachers learn computer science fundamentals and to really teach and inspire the next generation of STEM teachers.

So how do you see this through this partnership and the training of computer science teachers? Because they are directly building a pipeline for everyone, including communities of color, into the STEM and tech workforce, yet teachers need this training.

And so, once again, I think we need more resources for this, but I know in my district, again, in the city of Oakland, we care much about ensuring that all young people have access. And this is clearly a pathway out of poverty, but again, I don't think the budget is adequate enough for that.

Ms. SPENCER. Well, let me talk about Computer Science for All, a brand-new initiative we just announced, and also share a comment about Reading Partners. That is the program that I am a volunteer with. So the way Reading Partners works is there is an

AmeriCorps member who is well-trained in a very rigorous science-based, research-based reading curriculum program. So one AmeriCorps full-time member is in a school, and in my case here in DC, it is at Shaw Elementary School, and Elizabeth Strader is the AmeriCorps member. She has 83 of us, so there are 83 volunteers. We all go through training. We are matched with our mentee. Mine is a first grader. I have been doing this for 4 years, a different child every year, and I hate breaking up with them because I love, I love my children.

But what is great is, as I work through that rigor, at the end of the year I get a report card on my student and I see her gains in her literacy levels. That is a really good program. So Reading Partners is a great example of leverage, right? One AmeriCorps member is leveraging 83 volunteers. We are all committing and working with the students. So I am glad we have a great presence at Oakland.

Computer Science for All is exciting for us. So this is where we try to get very creative and figure out here is a problem. What can we do with our resources to do something different and unique? And I am always willing to experiment, especially when it is in the education arena.

So what we have done is we have set aside \$17,000,000 in our education awards, college scholarships. That is going to be set aside for up to 10,000 teachers over the next couple of years for them to use that towards training to learn coding, to learn computer science, to be able to maybe have them teach afterschool, summer courses. Some of our teachers need extra income. And so they are going to be able to do some service, in exchange for the service get scholarship money from us, they learn to teach these afterschool programs and summer programs, and integrate it into their classroom if that is appropriate.

We have got to get more teachers in the STEM area, and I don't know if this is perfect, but I am willing to try anything. So this is our first shot at this, and I think it is going to be exciting.

Ms. LEE. Thank you. Mr. Chairman, I would just say that if the Department of Ed. funded this, it would probably be millions more than what this budget suggests. And so once again, big bang for our bucks.

Ms. SPENCER. Thank you.

Ms. LEE. And thank you very much.

Ms. SPENCER. Thank you.

Mr. COLE. Thank you. We will next go to my friend, the gentleman from Philadelphia, for any questions he cares to ask.

Mr. FATTAH. [Audio malfunction in hearing room.]

Mr. COLE. Actually, you were here before Congressman Dent so—

Mr. FATTAH. Well, let me proceed then. Let me thank the chairman and thank you for your great service. You have a long line of people, you know, playing an extraordinary role in building this organization, and I think the storm clouds have passed and the Nation has fully embraced AmeriCorps under your stewardship. So thank you—

Ms. SPENCER. Thank you.

Mr. FATTAH [continuing]. Because I think it means so much for improving the life chances of young people throughout the country. And the service they provide, you know, I am convinced that they get more out of it than the very-needed service that they are providing to others.

So I visit schools regularly, and in dozens and dozens of schools in my district in Philadelphia in which when you show up, the AmeriCorps volunteers, corps members who are there both in our City Year program and community, there has been Learn to Serve efforts. You get older students working with younger students, which has been quite an extraordinary lift because both sets of grades go up—

Ms. SPENCER. That is right.

Mr. FATTAH [continuing]. Both for the tutor and the young people who are receiving the tutoring.

I met a young man who is in PowerCorps now, and he had recently been engaged in some antisocial activity and then had an epiphany, Mr. Chairman, and decided to move in the right direction and now is just doing great work at a community level.

So, you know, our job here is to dispense, you know, discretionary dollars. I can't think of a better place for us to be investing them.

And I got a chance to speak at a graduation, conclusion of a training session for some of your VISTA AmeriCorps members in Philadelphia, but they were from around the country and we were glad to host them.

So I don't know, as we go forward, because there is going to be a change in administrations, but I think one constant will be national service and AmeriCorps. And as you think about, you know, what is going on in the country—today is the founding of the Peace Corps in 1961 by John Kennedy—I know that you are now 22 years old. I know this because I was around, one of the cosponsors when we created this program. And there were some challenges, Eli Segal in Harris Wofford's period, and I was with Harris on Martin Luther King Day, that day of service and we had tens of thousands of volunteers—

Ms. SPENCER. Right.

OPPORTUNITIES TO GROW NATIONAL SERVICE

Mr. FATTAH [continuing]. In Philadelphia for that activity. But as you think about the bigger picture now for the Nation, not about, you know, whether or not we are going to, you know, be able to deal with small incremental bites, but if you would talk to the committee about what you see as, you know, the opportunities to further build on national service for whoever may be coming in as the next President and the next administration. I would be interested in your insights. You have seen the country, you have seen what is going on out there. If you would share with the committee—the chairman is interested in big picture and not just small picture issues. It will be helpful to us as we go forward to get a sense of what you think is doable.

Ms. SPENCER. Thank you so much for that very thoughtful question. And you mentioned two giants in the national service. Eli Segal, sadly, is deceased, but Senator Harris Wofford, he is doing

fantastic. And no coincidence I was inducted into this job on his birthday, April 9, so we share a great bond in many ways.

I would like to share with the committee that this year we will induct the one millionth AmeriCorps member. It is pretty exciting, just 21 years ago when this idea was conceived so that we will have one million.

So where does that take us? I am seeing these AmeriCorps alums all over the country. I went to a national conference on volunteerism that had some of the strongest nonprofits in the country in Houston last year, several thousand people, and the question was asked, how many of you are AmeriCorps alums? And half the audience raised their hand. They are now running nonprofits. They are engaging volunteers. They have taken what they have learned in their year of service and they are using that for the greater good of communities.

A longitudinal study tells us that 60 percent of AmeriCorps alums pursue public service. That is a great need. While we do need our young people pursuing STEM, we can't overlook teachers, public service, law enforcement, nonprofits, the faith community. We need leaders in these careers as well. So I am so pleased that national service helps influence young and old and how they can contribute back.

And one thing that excites me, too, is the number of young men who join AmeriCorps for lots of different reasons. Some are between college and high school or after college or trying to figure out their way and they serve in an education program. And so many of them have told me I have decided to change my major from business to education, from engineering to education, from this to education. And I ask them why? And they say when I am in the classroom, as a male figure, I can tell that these young boys are starved for attention and leadership in role models, and I am so drawn to the influence that I can give to them and I want to be in a position to do so. So I think there is a great future in attracting men to join as teachers as well.

So I am excited about the future. One thing from our research we know is that if you volunteer, especially at an older age, you live longer. This is research-based. You are happier. You reduce your stress. It has health benefits, physical health benefits.

As many of you may have seen, the 106-year-old who was in the White House last week and was dancing in the White House—

Mr. FATTAH. Dancing with the President, yes.

Ms. SPENCER. That is Grandma Virginia McLaurin, who I call a friend, who will be 107 in a week and we will celebrate her birthday. She is a current Foster Grandparent. She is a current Foster Grandparent, and she does a great job. She walks to her service, her school, and she says oftentimes people offer to give her rides; she says no, I need the exercise. [Laughter.]

Ms. SPENCER. But what is great is she is still contributing. And I have talked with her, and it is amazing.

So it is an opportunity for our young and our old. My challenge to young Americans in particular, is that everyone should give a year of their life either to our military or pursuing public service, joining AmeriCorps, doing an internship at a nonprofit, serving with your faith community, but give something back.

And I think that that is the direction we need to go in because I know it bonds America. When you serve with people from different walks of life on a common purpose, you become more tolerant of their ideas, their religion, their background, and that unifies Americans. In fact, it unifies the world. So I hope that is the direction we go in.

Mr. COLE. Mr. Fattah has managed to use your enthusiasm to get an extra 2½ minutes. That is very clever—

[Laughter.]

Mr. COLE [continuing]. Very well done, but for a good cause.

Mr. FATTAH. Thank you, Mr. Chairman.

Ms. SPENCER. Thank you.

Mr. COLE. Yes. I want to go to my good friend from Allentown, Mr. Dent.

Mr. DENT. Thank you, Mr. Chairman.

Well, it was worth the extra 2½ minutes. It was a good discussion. [Laughter.]

VETERANS AND MILITARY FAMILIES

Mr. DENT. In addition to serving on this subcommittee, I have the honor to serve as a chair of the subcommittee dealing with military construction and the VA. And recognizing that one of the focus areas of CNCS is veterans and military families, can you share with us how you are working with the VA at the Federal level and with individual State veterans' agencies that best coordinate those types of efforts to ensure that your investments are augmenting underserved areas or populations instead of creating redundancies?

Ms. SPENCER. Thank you so much. You have hit on something very personal to me. I am the daughter, granddaughter, wife, and stepmother all to men who served in all areas of the military, so it is very personal to me that we make this a focus of our agency.

And just to give you a little bit of the footprint, we love to count, and we have been able to determine that of our 75,000 AmeriCorps members and 270,000 Senior Corps volunteers, that 23,000 veterans are serving today in our programs. I am very, very proud of that because I do think it is an opportunity for veterans to continue to serve, and we welcome their expertise and what they bring to nonprofits and to solving problems.

Last year, we were able to support 780,000 veterans and military family members in our programs, in hundreds of programs that are focused on this either as a core part of the mission or as a part of their overall efforts.

So a couple of areas that we are working on, one is with Veterans Affairs that you mentioned that I think is something of great interest to them is to make sure that every veteran has the opportunity to use the G.I. Bill to the fullest extent. This is a great benefit that we provide our veterans. But sadly, not all of our veterans are successful in their experience in attending college and graduating. Far too few than should be graduate from college because they run into obstacles. Now, sometimes, these obstacles are returning back from war. It is a difficult transition not for all but for some, and it is hard to get right into going to classes and being free of maybe physical and mental needs and support at the local level.

So one of the ways that we decided to tackle this if you will is with a program called the Washington Vet Corps. And I love this program, and I have met these AmeriCorps members in Washington, in the State of Washington. The idea is that you take a veteran, and they become an AmeriCorps member, and they are placed in a college. And all the State schools in the State of Washington have this access to this program. That AmeriCorps member who is now a veteran is the key person for the veterans attending that public college to go to for any problem they have. It is a safe place for them to go and seek counseling, support, tell their stories, tell their needs, and then that veteran, who is an AmeriCorps member, can connect them in overcoming their problems.

And I will give you one very, very serious example. I met one of the AmeriCorps members who said that a veteran enrolled in college, female, mother of several children, came to her and said I am abused and homeless but I am using my G.I. Bill to help get ahead, but I have got to find housing and I have got to get away, you know, and have a safe place. That AmeriCorps member connected her to the resources that she needed. Those are the kind of issues that we are working on.

PENNSYLVANIA NATIONAL SERVICE MODELS

Mr. DENT. That is good to hear that. I also just wanted to mention, too, that I am pleased with the G.I. Bill benefits. It is a portable benefit. A lot of family members of veterans are taking advantage of it, and that is a very good thing. But thank you for that comment.

My final question deals with in your testimony you mention how national service investments, you know, helps the local communities, solutions, I guess, both in my district and across the Commonwealth of Pennsylvania where we are fortunate to have a number of very active volunteers and civil servants who make valuable contributions to our communities. Could you elaborate further on some of the programs that have been successfully implemented in Pennsylvania that may serve as a model for other States?

Ms. SPENCER. Well, I think one that was mentioned earlier is Power Corps. It is a great program, and this program takes mostly young people between the age of 18 and 28 who are having difficulties. They are out of school and not connected to jobs, and they need someone to give them a chance. And so what the program does is allow them to enroll as AmeriCorps members so they get the living stipend, the opportunity to go to college when they complete their term, but they get to learn skills. They get to learn about working in the environment. They get to learn trades while they are helping the community. That is a dual benefit because the individual is supported, and it may be the first time anyone has given them an opportunity.

But the community has helped with local needs as well like transforming a brownfield into a park maybe. So I am real pleased with that. It is something that I hope we can replicate around the country, and I think there is great demand for that.

PAY FOR SUCCESS

Mr. COLE. If I could, I would like to return again to an aspect of the Social Innovation Fund. And if I am correct, I think the Corporation is one of just a handful of agencies that has made awards using the Pay for Success contracting model in which private investors support initiatives to, for example, prevent homelessness or support youth development, and the Federal Government provides payment to the investors only if they achieve agreed-upon outcomes. Could you please tell me more about what you have done specifically in this area, how you evaluate the model, and what you are looking forward to in the next fiscal year?

Ms. SPENCER. Great, thank you. This is again exciting, and we are glad to be one of the first Federal agencies diving in to the Pay for Success-type model.

So the process, the way it works is our grants are helping organizations set up the model so that they can put together these Pay for Success models. And here is a great example of one that I have had a personal connection with. The Green and Healthy Homes Initiative in Baltimore, their goal is to go into these houses that are traps for asthma and other allergies. These houses have mold; they have other things that are harmful to children.

And one example that I heard about recently was a mother and her son. The son has a case of asthma. They lived in a house with mold, and this was in Baltimore. That son, a child, went to the hospital six times in one year. He missed 14 days of school. She is a hardworking mother. She missed 14 days of work.

So Green and Healthy Homes goes in and they do the full remediation work on that house and they get the mold out and they get the house healthy again. They spent \$7,000 doing this. The cost to the community is \$25,000 for the young boy to go to those medical visits and hospitals.

So the idea is that the health care organizations, the hospital will repay—when they set this up, they will repay Green and Healthy Homes Initiative that \$7,000 they invested in remediating that home, and it saved the hospital and the community \$25,000. But they only get repaid if the work is done, completed, and worked.

And how do they know it actually worked? Because the next year this young boy, after living in the healthy home, did not go to the hospital one time and he only missed one day at school and his mother only missed one day of work. It worked, but it was evaluated.

So we are going to set up all kinds of programs like this where the nonprofit can prove that they can solve the problem but don't get paid until they do so and it is evaluated. So our work right now is setting up the models, and I am really excited to watch this over the coming years. I think this is something that we all ought to look at in government.

Mr. COLE. Yes, it is a fascinating concept. Can you give me some idea of the scale you are talking about? I know you are testing this out and looking at things, so I am just curious about the size of the program that you mentioned.

Ms. SPENCER. We have eight grants right now, about \$12,000,000 investing today in setting up these systems, so it is brand new to us but it is very exciting. Jobs is another one, you know, getting jobs for people. I mean, it is a hard thing to get a job for a chronically unemployed individual who has been unemployed for two decades or so. But that is the exact kind of problem this Pay for Success should look at. And so it is not a big part of our portfolio yet, but I think it is a good part, and I think we are going to learn a lot from it.

Mr. COLE. I would ask you to keep the committee advised as you progress through this because it really is a pretty—this is an area where it is very difficult to measure success, and it appears to me at least in some ways you have and, you know, very tangibly, and that is just helpful to know.

Ms. SPENCER. Thank you. We will do so.

RESILIENCE AMERICORPS AND DISASTER RESPONSE

Mr. COLE. OK. One quick question and then we will move on. You know, I have seen what you guys are capable of doing after a disaster in my own hometown where AmeriCorps deployed and put people on the ground. It was a tremendous help to us after the tornadoes in 2013. But your request also includes a new program called Resilience AmeriCorps that is intended to help communities respond, you know, to extreme weather and other disasters. Define for me the difference a little bit. And I am assuming this is sort of a preemptive effort to prepare places, but just give me a little background on this if you would.

Ms. SPENCER. It certainly is. And I was leading volunteer and donations management under three Governors in Florida and one under the horrific storms of 2004 and '05. As we traveled the State, I saw so many ways that we could have done a better job in preparing the most vulnerable citizens. So this program Resilience AmeriCorps is about better preparedness and plans for cities.

It is a wonderful public-private partnership, so we are partnering with the Rockefeller Foundation, who is investing nearly \$2,000,000. Cities of Service across the Nation, 10 cities to start with, 20 AmeriCorps VISTAs, we are going to go to 15 cities soon, and these two AmeriCorps VISTAs in each of these cities will work with the mayor and his or her key team to put together a strong resilience plan with local nonprofits, business leaders, other organizations around a holistic plan in whatever their community is vulnerable of. Some communities are more vulnerable in certain perils, more vulnerable for floods, more vulnerable for tornadoes or hurricanes. Whatever is unique to that community, that is what they are going to focus on, so it is going to be a very individual case.

I think this is going to be a national model that we are going to want to scale, and I think mayors and county officials are going to be calling us and saying when can I get my AmeriCorps VISTAs to come in? Mayors tell me something all the time. They say, Wendy, I want to end veteran homelessness or have a resilience plan or make sure that every third-grader is on reading level in my community, but I don't have anyone else that I can commit to on my team to see this through. That is where AmeriCorps members

can step in in a mission-driven way, take over, lead the effort, be the instigator, coordinate the working groups. And they are doing it in a mission-driven way, getting experience and passion for it.

So you know what I ask AmeriCorps members? I say what is your biggest obstacle in your service? And you would think they would say the living stipend is not enough, the hours are too long. You know the one thing they say to me? I don't have enough time to meet all of my objectives. I wish there were more time. Because they approach their service in a 10-month window or a 12-month window like I have got to meet these objectives in this amount of time. And that is what I like about Resilience AmeriCorps. They are going to come up with great plans for these communities. So we are looking forward to it, and I will keep you apprised of its progress.

Mr. COLE. Thank you. I used Mr. Fattah's trick, so you might want to try it as well. I recognize the gentlelady from Connecticut.

FLINT WATER EMERGENCY

Ms. DELAUR. Thank you, Mr. Chairman. And let me play off of your comments, and this has to do specifically with Flint, about which I shudder when I think of 9,000 children who have lead poisoning, which is irreversible.

But your Pay for Success program and your Resilience AmeriCorps—and I want to get a sense of what—you know, we talked a little bit about what your folks were doing there now, but one of the great problems in Flint is looking at—two things. In your Resilience AmeriCorps, what I have found out about Flint is that the city itself and the mayor, she has no staff. There is nobody home. So she is trying to deal with this unbelievable crisis with an infrastructure that is nonexistent in terms of personnel, so forth. And the other issue is engaging nonprofits and others to be able to work with these families and these homes and these children about what their future is about.

Does this make sense to you in terms of what your mission is and where you can provide help in both of these areas? And I don't know the extent to which there have been conversations about any of this with, you know, the folks in Flint.

Ms. SPENCER. Well, we are working very closely with Flint. In fact, I met the mayor recently. She was attending a meeting here in Washington, and we almost shed a tear together over this because it is a horrific problem, and I can't imagine what they are going through.

But there are so many ways that we can help and are helping and working on a task force, working very closely with the United Way of Genesee County there, who is taking a great lead. We sent in immediately, as you mentioned earlier, a team of AmeriCorps NCCC members. Now, these are the 18- to 24-year-olds that can work circles around any of us, and I was delighted to see a local television reporter about 2 weeks ago shadow the team members for an afternoon and go door-to-door as they were delivering water and filters and information about their health and what they needed to do.

So we are getting supplies delivered to people, we are recruiting volunteers, we are managing volunteers. We have another about 30

AmeriCorps members who are either serving in schools or other areas who are being cross trained so that they can be a part of the education component.

I am also looking at putting an AmeriCorps member in every school who is a nutritionist because we can—

Ms. DELAUBRO. The two areas—

Ms. SPENCER [continuing]. Overcome this with—

Ms. DELAUBRO [continuing]. Are nutrition—

Ms. SPENCER. Yes.

Ms. DELAUBRO [continuing]. Education.

Ms. SPENCER. Yes.

Ms. DELAUBRO. And that is where—and I am going to work like hell to be able to get the Department of Agriculture to be able to take these kids and get them WIC help from age 5 to 10 instead of just—

Ms. SPENCER. Right.

Ms. DELAUBRO [continuing]. Up to age 5. But those are the areas, nutrition and education, where we can bring some—

Ms. SPENCER. We can put a trained AmeriCorps member from one of our programs like FoodCorps and others, nutritionists literally in every school there teaching the children, their parents, the faculty, the community leaders. That is going to help mitigate some of this. And this is a long problem, but we have got to make a surge and we have got to do it now. And we are prepared to help.

Ms. DELAUBRO. OK. I really do want to talk to you before I go to Flint on Friday with the direction that you would like to go in, what we can—

Ms. SPENCER. Thank you.

Ms. DELAUBRO [continuing]. Talk about, what is there, et cetera, because we need to move on these things.

Ms. SPENCER. Thank you.

OPIOID CRISIS

Ms. DELAUBRO. These kids are already suffering.

Now, I don't have to tell you about an opioid problem that we have, so let me get right to it. And I know you have people in correctional facilities, you have people everywhere. Do you have a strategy about leveraging your program in terms of that opioid crisis? And are your folks getting trained on abuse, et cetera?

Ms. SPENCER. It is a crisis, and every time I meet with a Member of Congress, a Mayor, a Governor, it seems like now they are bringing it up. And that is a unique, different trend. And I think we have all got to focus on it. And this is an all-hands-on-deck. There is not one sector that should not be involved in this.

Let me give you one example that I think is a shining example, and it is in one of the toughest areas in the country, and it is in eastern rural Kentucky.

Ms. DELAUBRO. Yes.

Ms. SPENCER. It is actually in Chairman Hal Rogers' district.

Ms. DELAUBRO. Right.

Ms. SPENCER. He had the vision several years ago to start an organization called Operation UNITE to focus on this problem. And what we did early on is co-invest with his nonprofit, and we have 44 full-time AmeriCorps members serving each year in Operation

UNITE to focus on two things: anti-drug activities at the earliest ages in elementary school and also focus on education because a smarter child and someone who is interested in education and focused on that is not going to be focused on things like drugs and things that get them in trouble.

So we focused on math, and they are tutoring thousands. The math scores, I am pleased, on our evaluation have increased by 34 percent since we have been working on them, and that is up actually a point over last year, so we measure it every year.

But the number of children that are joining these anti-drug clubs, I have gone with the chairman to tour these schools, I have seen rallies. These things work because it gets it into the young people's minds early that you must be focused on something positive and that drugs are bad for you. You have to have a strong drumbeat all the time. This can't be occasional, it can't be—you know, it has got to be a part of the school's culture, the community's culture.

And these AmeriCorps members who are from eastern rural Kentucky—and I have met many of them who lost family members and friends to drugs who died from them, and they are very passionate about it.

So Chairman Rogers has asked me to come talk about this at his annual conference in March, his prescription drug conference. And I am going to head up the panel, and we are going to talk about how service can provide a solution. And it is about intervention.

Ms. DELAUR. Right.

Ms. SPENCER. We have got a lot of areas we need to work on, but we have got to work on intervention first and foremost, and that is something that AmeriCorps members, Senior Corps volunteers, and volunteers like you and me can do as well.

Ms. DELAUR. Thank you. Thanks very much.

Thanks, Mr. Chairman.

Mr. COLE. We have all caught on to Mr. Fattah so it is—
[Laughter.]

TRAINING AND TECHNICAL ASSISTANCE

Mr. COLE. Ms. Spencer, in fiscal year 2016 omnibus we reinstated the authority of the Corporation to support training, including at the State and local levels, through set-asides in AmeriCorps. Would you describe what plans you have for the Corporation to use this authority in the coming fiscal year?

Ms. SPENCER. Well, training is so important for a lot of reasons. I mean, one is there are a lot of rules and regulations now, more requirements on Federal grantees than there were when we started 21 years ago, and we have to keep pace with that. There are a lot of reporting requirements. We have got to make sure that we are collecting the appropriate data so that we can make sure that our investments are in the right areas.

We have got to make sure that it is working because if we invest Federal resources, match it at the local level, and it is not working at the scale that it should, that is okay. You need to know, you know, what areas you are best at. You can't be good at everything, but you should focus on things you are good at.

So it is important that we are training our grantees, our intermediaries. We work very closely with 52 Governors' Commissions on service and Volunteerism. They are managing three-fourths of our AmeriCorps grants. So once that grant goes to them, we can't just trust that it is going to be managed well; we have got to partner with them to provide training for them. And I ran a Governor's Commission on Volunteerism in Florida, and I was a recipient of the funds from this agency, so I know how important it is to have the resources for training.

So it is something that not everybody wants to fund, but if you don't do it smartly, you won't do it well. So that is why I am a big proponent of training funds. We are very smart in how we do it, very cost-effective, and I am very pleased with the direction. We are holding four regional training conferences throughout the country where we will have probably 2,000—the vast majority of our grantees who are running the largest programs and middle-sized programs will be attending this year. I will attend every one of those, and we will talk about the need for criminal history checks, on time every time, my new theme. We will talk about the reporting, we will talk about prohibited activities, we will talk about what it means to manage a Federal resource, the public tax dollars' resource and do so with efficacy.

So I am passionate about it. I think we ought to continue with this, and I appreciate the investment that you have given us with this.

EVALUATIONS

Mr. COLE. Somewhat related, let me ask you, your budget asked for very little in the way of increases, but one area it did was \$2,000,000 for evaluations. So that is a fairly substantial increase. I think it was 50 percent over what you have done in the past. So tell us how you intend to use those dollars. How much of it stays with your headquarters? Is any of it distributed out through the organization so some of the evaluations if you will are local if—

Ms. SPENCER. It is a combination, and I would be happy to provide you and your staff with a detailed list, but one is going to be with the Social Innovation Fund as well. I mean we have got a lot of Federal dollars and also private dollars invested, and we have got to make sure, especially since this program is one of our newer ones, that it is working well. So certainly some of that is going to go into that area.

It also allows us the opportunity to select some of our largest grantees and do a full-on random control trial, third-party evaluation like we did with the Minnesota Reading Corps. That is a large program. It is in 12 States, millions of dollars invested in that. I would like to do another evaluation like that. So that will be really co-investing with one of our large grantees, yet to be determined, but that is important, especially when you have an area like early childhood education that you want to learn from and you want to replicate and you want to scale it. So unless we do evaluations, we are not going to know full on if that is something we should replicate.

So with the Social Innovation Fund, with our goal to select other large grantees, I think that combination is going to be a wise investment.

Mr. COLE. Well, no question in my mind it is a worthwhile use of the money. Again, you know, one of the tougher things is being able to measure outcomes and produce evidence, quite frankly. It is tight times for budgets everywhere, and so any time you have got something that can show you something works or, frankly, saves you money by saying this is really a dead end for us, money spent figuring that out is still well worth it so you can redirect the resources instead of, you know, misdirecting them, quite frankly.

Let me, with that, go back to my friend, the gentlelady from Connecticut.

Ms. DELAUR. Thank you very much, Mr. Chairman.

Let me ask a question about the Senior Corps in which you—

Ms. SPENCER. Yes.

SENIOR CORPS

Ms. DELAUR [continuing]. Have talked about their work as Foster Grandparents, tutors, mentors, et cetera. And I just know that there are about 3,000 Senior Corps volunteers in Connecticut, so—

Ms. SPENCER. That is right.

Ms. DELAUR [continuing]. I am grateful for that effort. And, look, we have got more and more people retiring every day and baby boomers, et cetera, so it looks like there would be a large population of people who will knock at your door.

The budget, though, for Senior Corps programs is lower than it was in 2010, and the budget request has been flat for the past several years. So this sounds like one of the best bargains for the Federal Government, Ms. Spencer. How much does it cost to support a Senior Corps volunteer? What kind of support do we need to provide in order to ensure that they are continuing to serve our communities?

Ms. SPENCER. Well, you may have hit on that there could be a very strong argument that the Senior Corps program may be the best value in the Federal Government. It is a wonderful opportunity. In addition to the health benefits of seniors volunteering—and, by the way, next month, I will be qualified to be a Senior Corps volunteer as I turn 55. So there is hope for me in my volunteer life in the future, and I am proud of that.

The two ways we operate these programs, Foster Grandparents and Senior Companions, fairly similar. These two programs are actually means-tested programs, so these are for seniors. This particular program is in great need, living at the poverty level. They receive \$2.65 an hour as a stipend to defray some of their costs for serving. On average, they serve in the Senior Companion program about 15 to 20 hours per week, and in the Foster Grandparent program closer to 30, 35 hours per week.

Foster Grandparents are generally in schools. There are some exceptions to that like in juvenile detention centers. And Senior Companions are serving in homes doing one of two things: keeping other seniors living longer because they are there to help them with some of the basic needs and also providing respite care for

family members who can't get out of their home unless they have some respite to do so during the week.

While \$2.65 doesn't sound like a lot, to someone who is elderly, doesn't have a lot of resources to depend on, doesn't have a good retirement but does have the physical ability and great nurturing ability to get into schools, it has something to offer, which all of our Foster Grandparents and our Senior Companions do. That \$2.65 can mean a lot to them. It can help them with their basic medical needs, transportation, some basic things like food, their utility bills.

So we are solving two problems here. We are providing caring and nurturing adults in schools, which the teachers are so grateful for, but we are also providing a benefit to the senior.

Now, the other program is RSVP. That is not a means-tested program, but that has the largest participation—about 230,000 seniors are serving in RSVP. So think of it like a mini volunteer center, if you will, for seniors. And they show up and say "I would like to serve in education" or "I would like to work in the environment" or "I would like to do tax returns for the poor." So we connect them with this.

Those grants average about \$75,000 to each organization—the individuals don't get a stipend—to the organization, and the organization uses our funds to manage and coordinate volunteers, many of them, hundreds of them. So that is a really great bargain as well.

SUMMER OPPORTUNITY AMERICORPS

Ms. DELAUR. So we are getting great return on a very minimal investment in this program.

Let me ask you about summer youth programs. You have got Summer Opportunity AmeriCorps, you are going to create up to 20,000 positions for low-income students, high school age in the next 3 years, help them build skills and earn money for college. Can you tell us a little bit about this program and how they are going to deal with low-income kids?

Ms. SPENCER. So our young people are really faced with a lot of tragedy in communities across the country today and obstacles that get in their way from being successful. But one of the ways that we have found to do an intervention is to get them engaged in something positive. Service can be the one thing that our young people—and this is targeted at high school students in the summer who have a lot of time on their hands and can get in trouble while their parents are working and they are left at home alone. But if we can coordinate activities and work with great organizations who work on summer learning loss, summer programs, Boys and Girls Clubs, YMCAs, these great programs that are proven that they can manage young people in something positive.

We are going to set aside some college scholarship money as a carrot, if you will, so that they can use these funds, serve during the summer, get involved in all kinds of great activities, run and managed by these programs that do it so well, and then set aside a scholarship for them that they can look to and say, you know, I now am going to go to college because there is a fund with my name on it. I can't tell you how many young people I have met who

have said I wasn't going to college until I earned my college scholarship from AmeriCorps and I said why not? It is sitting there waiting on me. I hope that same incentive will be there for these young high school students.

Ms. DELAURO. Thank you, Mr. Chairman.

Mr. COLE. Thank you. Mr. Harris, we haven't given you a lot of time, but we are prepared to go or I can take some questions if you are sort of getting your—

Mr. HARRIS. If you could, I would appreciate it.

SELF-SUFFICIENCY OF GRANTEES

Mr. COLE. OK. No, I would be more than happy to, and then we will go to you next.

CNCS, you support an enormous number of services conducted by tens of thousands of organizations across the country, so you probably have more experience in dealing with different types of volunteer and civic groups literally than anybody else in the Federal Government. When you are making your decisions on grants, do you look at whether or not these particular organizations are self-sufficient, have the potential to become self-sufficient? Is there sort of best practices, if you will, that you can extend to these organizations so that, you know, over time they sort of stand up on their own? It doesn't mean we wouldn't continue as the Federal Government or your agency to have a relationship with them, but obviously, the more they can do for themselves, the more you can spread your services into other areas.

Ms. SPENCER. You know, that is a great question, thank you. And it is a bit of a blend, and I had a lot of experience with this working at the Governor's Commission on Volunteerism in Florida because you want to do two things. You want to find nonprofits who have new, innovative ideas that may not be tested yet but they want to tackle a problem in the community, and you also want to blend it with very experienced nonprofits who really know how to engage citizens in service. And I think it is important that we have a good blend.

We also—it is important to look at vulnerable populations, Native Americans you know we are leaning in. We have invested the highest amount in our tribal communities this year, in the last 10 years. It may be the largest in our agency's history but we know in the last 10 years, there are great needs in our tribal communities. Over \$5,400,000 we are investing now. Rural areas, our assessment about 42 percent of our grants are in rural areas. It is very important to support rural communities. This youth opportunity that we talked about, these young people who are out of school and out of work, seniors, and others.

So we look at organizations who are tackling difficult problems, have a plan, have an ability to scale what works if they have been in the business for a while, but they also can demonstrate that they have strong local support. That is important to us. This is not, you know, just a public program. As, you know, I shared in my opening remarks, we have been able to now exceed our Federal funding for the first time ever with local support. And so now we can call it a private-public instead of a public-private partnership. And we look at that. What do you have at the local level that says

that we believe in your cause so much so that we are going to invest locally?

We are also using evidence. This is relatively new. We are looking at preliminary evidence or any evidence that they have a plan that actually works. But I also don't want to go too far. I always want to increase the opportunity for applications to bring us ideas that are untested. That is OK. We need to be a breeding ground for new ideas. But we also need to make sure that we are monitoring that very closely so that we make good decisions.

So I think our application process, while solid, we are always looking at new ways to review it. But those things are important, local support, evidence it works, or a new idea that you want to test, and you are addressing the problem that really needs to be addressed in the highest and best use.

PROMISE ZONE INITIATIVE

Mr. COLE. Related to that, would you please describe the Corporation's role in the Promise Zone Initiative and how much funding is allocated this year? What are you expecting to be doing in 2017?

Ms. SPENCER. I love place-based initiatives because it is where we get to really work with the community leaders and focus very clearly on a problem. I will get you the exact number of the—not only the number of grants but the number of members or volunteers who are serving and also the amount of funding we are investing in that, and we will follow up with you.

But this is an area that I feel like the administration has leaned in on, and I really appreciate the opportunity for the Federal Government to be able to actually shift. We need to be flexible. We need to be able to turn on a dime like Flint, which was mentioned. I mean, we had AmeriCorps members moving in before it was declared a disaster. We have got to respond quickly. We have got to try to make sure that our processes don't inhibit us from being able to turn in to problems that arise in local communities no matter what that is.

So we have got a great—I personally did an announcement in Indianapolis with the Promise Zone there, great local community needs there. And we are able to be a very good coordinator. Sometimes, that is all it takes is—we have committed to providing AmeriCorps VISTAs—those are our capacity-builders—to go in and be able to coordinate organizations in a community around the need. If they need to double-down with direct service like AmeriCorps and NCCC and send in teams of young people or do a grant application for an AmeriCorps program like I mentioned with Operation UNITE in eastern rural Kentucky, whatever the need is, working with the faith community, that may be a real important part of the fabric of the community that needs to be better engaged. We can coordinate that. So Promise Zones is an important area, and I think it is one way the Federal Government is showing flexibility.

Mr. COLE. Thank you.

Mr. Harris.

GRANT MONITORING

Mr. HARRIS. Thank you very much. And thank you. As I am sure the chairman said, we have multiple hearings so I am sorry. I was down the corridor at one.

Let me just ask a couple questions. First, just a kind of administrative question because on—and I apologize if you covered it before, but on page 59 of the book, you go over the CNCS strategic goal operation measures, and curiously, you set a goal of, you know, a monitoring activity having to do with “complete all grant monitoring activity as identified in the annual monitoring plan and follow up with grantees where necessary,” where you would think that your goal would be 100 percent of doing that.

You know, you started 89 percent in 2013 and then it actually went down to 85 percent for all the years with the goal of fiscal year 2016 to be 85 percent. Why wouldn’t it be 100 percent your goal? I just have—you know, as we look at these grants, and they are widespread, and believe me, I have had a Habitat for Humanity, you know, singing your praises in my office the other day. I get it. But why would we want 100 percent accountability? Why are we happy with 85 percent accountability?

Ms. SPENCER. Well, thank you so much for the question. And I am not sure we would ever be happy with anything under 100 percent if we have the ability to do so. We have got about \$740,000,000 invested in around 4,000 grants around the country, and 50,000 locations is where we have a presence where we have at least one AmeriCorps member, Senior Corps member, or one of our grants enrolled in a location. So I think it is a matter of balance and what we are capable of doing. And this is where we talked earlier about training and leaning on our intermediaries, our Governors’ Commissions on Volunteerism, and some of our larger programs to help us.

So monitoring is very important. We are constantly working on it. It is our checkpoint. It is how we find out if it is working. It is where we find problems if we need to address those. So I share your frustration that, you know, should we be at 100 percent? I think that would be great, but I know it is probably just a matter of balance. And we will continue.

And as you have practices from your seat, observe in other Federal agencies or the private sector, please share this with me. I am always looking for practices to improve our monitoring processes.

DRUG ABUSE PREVENTION

Mr. HARRIS. And, OK, like I say, this is not my specialty but I would say that in the private sector I would be surprised if they didn’t have controls that actually looked at 100 percent of their shareholder dollars being protected this way. And, you know, these are taxpayer dollars, so I would just say, you know, I wish your goal were 100 percent, you know, not 85 percent for fiscal year 2017.

Let me just ask because one of the areas that you are supposed to be encouraging community service in is the health area. And I have looked through the book and I can’t find examples. Maybe you know of some. The drug abuse and drug use is a huge problem,

every community, every community. I go to a town hall meeting, I will tell you people don't talk about, you know, gee, it is the—because I see one of the things Baltimore is, you know, tree canopy, they don't want to know about tree canopies. They want to know about why did I have, you know, five people overdose in the local emergency room last week.

So I want to know what you are projecting in fiscal year 2017 to address that specific issue about health because I think their role for volunteers and their role for new graduates and things. So what specifically are you doing in order to address that issue?

Ms. SPENCER. Thank you. And we did talk a little bit before you were able to come in about a great program that we have partnered with Chairman Hal Rogers on in eastern rural Kentucky that could be a fantastic model for the country. And I have been sharing that with Members of Congress who are very focused on this and Governors and mayors as well. And it is having full-time AmeriCorps members focused at early ages, in elementary schools, middle schools, anti-drug movements, drug rallies, Safe Sons for young people to talk about their observations and the positions they are in, where they are affected by drugs. And sadly, these children, unlike when I was raised, have actually seen family members and neighbors die. And it is tragic. And I do agree with you. I think this is an area for service. I think volunteers in the faith community can do more.

We also have Community Health Corps. It is probably our largest organization. And I would love to provide details to you personally at a later time, but a little over 500 full-time AmeriCorps members, many of which are going to pursue the health sector as a career, but they are testing it through AmeriCorps. They are serving in community health clinics, they are learning about health needs, nutrition, and other things, and they are making a great impact as well. So I would love to meet with you and share that with you.

Mr. HARRIS. Thank you. One just brief question if I might, Mr. Chairman. Do you have a zero tolerance policy for your volunteers with regards to drug use?

Ms. SPENCER. Yes, we do.

Mr. HARRIS. Any kind of drug, including marijuana where it is legal—

Ms. SPENCER. Yes, we do.

Mr. HARRIS [continuing]. In the States? OK. Thank you very much.

Mr. COLE. Next go to the gentlelady from Connecticut.

SUPPORTING VETERANS AND MILITARY FAMILIES

Ms. DELAURO. Thank you, Mr. Chairman.

I want to just look at the veterans' area again if I might. Connecticut has a large population of veterans and active military personnel, and you support military families and veterans. And you talked about the number of those who have joined your effort, so I think it is a win-win.

Now, you have a Veterans and Military Families Steering Committee, and I understand that was convened recently to look at more services that you all can provide. What were the rec-

ommendations of your steering committee? Do you have waiting lists for services? And just in terms of—I know you talked about the G.I. Bill and other areas in here—how can we in this area provide increased support and effort by both increasing the number of veterans who are engaged in the effort again and looking at the kinds of services that they might be able to provide?

Ms. SPENCER. Let me share with you two ideas we are working on, and I think we are very close to making this happen. It is on the front end and on the back end of military service. When someone leaves the military service, they are handed a great tool from their service to transition them out of service. What we are trying to do is get in the manual the opportunity for them to serve in AmeriCorps written down, I mean, in that book so they can see that joining AmeriCorps could be one of many opportunities.

Many of our veterans have the ability to go right in and get a job in the private sector or the public sector. Many are going right into college, but some need a little more transition, and I say that from a point of talking to these veterans who have told me this. And what AmeriCorps does for them is it gives them that opportunity to transition gently to a sense of normalcy from the war zone to stateside while we get to take advantage of their great co-ordinating skills. They offer great skills to us and organizations. So it is a win-win. So if I can get that opportunity in the formal book, that is going to be one way.

Another way is—and this is a little loosely connected, but think about what it takes for a young American to step into the recruiter's door of what has gone on in their mind they have said I am going to join the Army? Only to find out oftentimes that they cannot join because they are overweight, test scores, physical limitations. At that moment I want the recruiter to hand them an AmeriCorps brochure and say we are not a good fit for you, but you have great skills and assets. Would you consider joining AmeriCorps? And here is the pathway to do so. Because we don't have any restrictions. In fact, we encourage people with disabilities to serve with us, people with limited education. We want all Americans. So it is a little bit different, but you see where there is an opportunity there.

Ms. DELAUBO. Right. What are the veterans' organizations that you tap into?

Ms. SPENCER. Like American Legion Auxiliary—

Ms. DELAUBO. Yes—

Ms. SPENCER [continuing]. Is a great one, I mentioned the Washington Vet Corps.

Ms. DELAUBO. Right. Right. Right.

Ms. SPENCER. There is a veterans' program in Virginia. I mean, there are a lot of them around the country, and they are local. You know, these are local grants. Most of them are going through their Governor's State commission, and the commission is selecting them at the local level. And some are not national nonprofits. Some are local organizations that have decided to focus on veterans in the community. And a lot of them are in areas where you just happen to have large military bases so they have a higher population of veterans.

Ms. DELAUBRO. Do you think that they know what a resource you are to their effort?

Ms. SPENCER. Not enough.

Ms. DELAUBRO. OK. Yes, I am just trying to think of—

Ms. SPENCER. No, not enough.

Ms. DELAUBRO. Are even—

Ms. SPENCER. We need more help in getting that word out.

Ms. DELAUBRO. Or even when we are dealing with the issue of substance abuse and so forth.

I would on that point just say that the specific areas that you function in, I think there needs to be a lot more understanding, marketing of where you are and what you are doing because I think that that helps us to avoid, you know, in years past, folks who wanted to eliminate these kinds of services and serious cutbacks in the mission that you have laid out.

I don't believe there is enough of an understanding of, you know, the functions that you are providing. I think there are many folks, and I don't know if you share this view, Mr. Chairman, that are here who think, OK, well, this is a large sum but you can go off and stay on the public—you know, get, you know, a stipend and so forth, and why should we be doing that and not understand the gap that is being filled in this whole range of services, you know, that you provide. And we would love to talk to you more about that.

And just let me say I was so honored to be able to receive the—and it is not in a self-serving way. I can't tell you how much it means to me—

Ms. SPENCER. The Kennedy Lifetime Leadership Award.

Ms. DELAUBRO. The Kennedy award, it really means so much to me personally, and I can't thank you enough for what you are doing or how we can expand what you are doing and tap into these resources, so thank you very much.

Mr. COLE. Would the gentlelady yield for just a moment—

Ms. DELAUBRO. I would be happy to.

Mr. COLE [continuing]. Just to respond to your remark? And this is something certainly Ms. Spencer ought to be aware of. You would be amazed at the number of very conservative Members that I have that come and visit with me about your programs and what they have seen in their districts. You know, you really would. And, you know, it is kind of like cut everything else in government but you have got to leave this, you know—

Ms. DELAUBRO. That is correct.

Mr. COLE [continuing]. Particularly—what is it—is it Bright Lights, the education program you have in cities that—I had a number of Members who had seen that in action in their districts and felt like it just really made a dramatic difference. And you in particular would be shocked—

Ms. DELAUBRO. I would not—right.

Mr. COLE [continuing]. At the names.

[Laughter.]

Ms. DELAUBRO. I would be happy to know that, Mr. Chair.

Mr. COLE. I have a whole secret list of allies for you—

[Laughter.]

Mr. COLE [continuing]. But I am afraid to put them in your hands. But, no—

Ms. DELAUBRO. Let's list them.

Mr. COLE. These really are programs because I think—

Ms. DELAUBRO. Unbelievable.

Mr. COLE [continuing]. People see them very directly in their communities in a way that they don't see other parts.

Ms. SPENCER. Yes.

Mr. COLE. Look, you don't see the National Institutes of Health directly in your community, you know, in a way that you will see a group of kids immediately after a disaster or you are going just as a Member visiting in a local school district and here is this program and teachers and kids alike are bringing it up to you.

So, no, your best advocates, frankly, are obviously your AmeriCorps members and then the people whom they serve.

Ms. SPENCER. Yes.

Mr. COLE. I mean, you see it a lot so—anyway, I will yield back to my friend, the gentlelady.

EMPLOYERS OF NATIONAL SERVICE

Ms. DELAUBRO. I would just end with this. There is always a quote I use that comes from a woman who served in this institution who I have a great regard for, and that is Shirley Chisholm, the first African-American woman who served in this body. And she said, "Public service is the rent you pay for space on this Earth." Thank you for the public service that you give and that you are inspiring young people to give as well. Thank you.

Ms. SPENCER. Thank you. Well, it is actually carried over now to America's employers, and they are taking notice. A year ago we announced Employers of National Service, and we asked employers all over the country to lean in and recruit AmeriCorps and Peace Corps alums, give them an opportunity. They have given to their community. Give them an opportunity. I am so pleased to report today that we have 339 employers from all over the country who represent 1,777,000 jobs. These are employers like Delta Airlines; Disney; Comcast NBC Universal; the States of Montana and Virginia; cities like Phoenix, city of New York, Philadelphia, Nashville; colleges like Arizona State University, of course nonprofits galore, and they are telling us we are not doing this to get on some list. We actually hope they apply. We value the fact that these AmeriCorps members have a mission-above-self, organization-above-self sort of DNA. They work with a team. They are the kind of people we want to bring in our organizations. And many of our workforce are an aging workforce, so they are looking to replace their aging out and their retiring employees.

So I am so thrilled that America's employers are seeing the value of AmeriCorps and Peace Corps, which is our sister in service, does a great job. So, you know, it is getting noticed. And I am so glad to hear, Mr. Chairman, that your colleagues are talking about it. It tells us that our education work, to demonstrate, asking you to come out and see firsthand is working. So I am really thrilled with that, and we want to do more.

Mr. COLE. Unless my friend from Connecticut has further questions, that, I think, is the perfect note to end this particular hearing.

ing on. Ms. Spencer, I want to thank you very much for being able to come and participate with us this year. We will try and promise it is not 16 years—

[Laughter.]

Ms. SPENCER. Thank you.

Mr. COLE [continuing]. Until you come back. Then you will be a fully fledged member of Senior Corps.

Ms. SPENCER. That is right.

Mr. COLE. And thanks for the great work that you and your colleagues do all across the country and the sheer number of ways that you have been able to, you know, bring out what is best in us as a people and sometimes institutionalize it and expand it. It is something you should be very, very proud of. And obviously, the people that work with you and preceded you have been doing this for a lot of years as well, so just thanks for your effort on behalf of the American people.

Ms. SPENCER. Thank you. This is a true honor to serve in this role, and it is an honor to support you and your goals in your districts. And we really appreciate the support from Congress. Thank you so much.

Mr. COLE. Thank you. With that, we are adjourned.

WEDNESDAY, MARCH 2, 2016.

**SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES
ADMINISTRATION**

WITNESS

**KANA ENOMOTO, ACTING ADMINISTRATOR, SUBSTANCE ABUSE AND
MENTAL HEALTH SERVICES ADMINISTRATION**

OPENING STATEMENT

Mr. COLE. Welcome. It is wonderful to have you here, and we will go ahead and open the hearing. Today, we are here to discuss the budget request from the Substance Abuse and Mental Health Services Administration, an agency in the Department of Health and Human Services.

I want to thank Acting Administrator Kana Enomoto very much for having you here today, and I look forward to hearing your testimony.

I will start by saying I very much appreciate the increases the administration put forward improving access to mental health services, targeting suicide prevention funding for the most at-risk groups, particularly tribal populations, and increasing vital substance abuse treatment and prevention programs. I think these are all areas we can agree need attention.

But I share the concerns expressed last week at our hearing with Secretary Burwell that mandatory funding is not a realistic option. I must stay honestly within the jurisdiction of this committee and address these problems through available discretionary resources.

I share the sentiment expressed by Chairman Rogers last week that we must find solutions to the opioid epidemic within the confines of the appropriations process. As many of you know, rising rates of opioid abuse and death are alarming. Drug overdose was the leading cause of injury-related death, and among those 25 to 65 years of age, drug overdose caused more deaths than motor vehicle crashes.

So we are deeply committed to finding better approaches to stop the growing epidemic of heroin use and prescription drug abuse. Last year, we made several investments in this area, and I look forward to working with you to continue this work in the coming year.

But I do want to stress—and I will be asking you questions—this whole question of mandatory funding is one that troubles me greatly because, frankly, we don't have the jurisdiction in this committee to do that. And my political judgment at this point is that that is unlikely to happen.

But you know, there may be discussion going in this place that I know nothing about. That happens all the time. But, so if you are involved in some, I want to know about that. And if not, then we

have got to figure out other ways to help you achieve the objectives you outline because, again, they are worthy goals.

With that, I want to yield to my subcommittee ranking member, the gentlelady from Connecticut, Ms. DeLauro.

Ms. DELAUB. Thank you very much, Mr. Chairman. Thank you for holding this hearing.

And I want to welcome Ms. Enomoto. We look forward to talking with you today about, as the chairman pointed out, the critical programs that fall under the Substance Abuse and Mental Health Services Administration purview, as well as the budget proposal for next year.

I want to start by saying a thank you to Chairman Cole because last year we were able to make important investments in the Labor, HHS bill altogether, including an increase of \$160,000,000 for SAMHSA. We were able to secure a \$50,000,000 increase to the mental health block grant, and a \$38,000,000 increase to the substance abuse prevention and treatment block grant program for 2016. Many families without healthcare coverage or whose insurance will not cover mental health or recovery programs rely on the services that are funded by the grants.

We were able to more than double the funding for medication-assisted treatment for prescription drug and opioid addiction through your targeted capacity expansion program. But I do have a worry that we are not going to be able to make these kinds of increases again without a stronger allocation.

Last year's omnibus moved the Federal budget in the right direction. We raised the caps on defense and nondefense discretionary spending, and we increased what was much-needed funding for programs that support our economy and the quality of life of citizens across the country.

The chairman has heard me say this before, but I am troubled that Labor, HHS, that our bill received only a fraction of its fair share of the \$66,000,000,000 increase provided in last year's budget deal. While the other nondefense subcommittees received an average of 6.9 percent last year, Labor, HHS increased by only 3.4 percent.

This subcommittee represents 32 percent of nondefense discretionary spending, and in my view, our allocation should be proportional to that figure. So I hope that we will see that realized this year.

SAMHSA's programs aim to reduce the impact of substance abuse and mental illness on our communities through prevention, treatment, and support during recovery. The programs are more important now than ever. As the chairman alluded to, we face a public health crisis in opioid abuse. The rise in that abuse across the country is sounding off alarms that we need to pay attention to.

We face an epidemic that requires a response from all levels of government. Every day over 100 Americans die from drug overdoses. It outnumbers the deaths from gunshot wounds or vehicle crashes.

The rise in opioid abuse across the country is distressing. Of the over 47,000 drug overdose deaths in 2014, heroin was a factor in over 10,000 deaths. Opioids were involved in almost 21,000. Sadly,

the deaths are likely undercounted. Thousands more people are addicted or in recovery.

We also need to expand access to naloxone in our community. I have urged the Food and Drug Administration to reclassify naloxone from a prescription to an over-the-counter medication so that more will have access to this lifesaving drug.

Supporting SAMHSA's work is essential to the well-being of our citizens. We can't afford to wait to act when addiction affects the lives of so many of our neighbors, our brothers, our sisters, our community members. We need to invest in programs that put Americans on the road to recovery, which brings me to the topic of today's hearing, the SAMHSA budget request for 2017.

There is so much good in this budget proposal and I support those efforts. I especially want to highlight the proposed increases to the President's Now is the Time initiative, which began in the aftermath of the tragedy at Sandy Hook Elementary School, still so fresh in all of our minds.

The budget request includes an increase of \$7,000,000 for Project AWARE, which helps to identify high school kids with mental illness and refer them to treatment, and it includes a request of \$10,000,000 for a new program to train peer professionals.

On the substance abuse side, I was glad to see that the request included \$460,000,000 for opioid use disorder treatment. Treatment of opioid abuse is critical. However, I am wary that all the funding comes on the mandatory side of the budget, which is unlikely to happen.

Which is why I will be introducing a bill that would authorize an additional \$1,000,000,000 in discretionary dollars per year toward substance abuse to support community clinics, and expand access to treatment for individuals with substance abuse disorders. Treatment seems to have the biggest shortages throughout the country. That is what I have heard from the folks all over the country.

It is the responsibility of this committee to fund SAMHSA programs. We need to increase the subcommittee's allocation to support mental health, and to address the opioid epidemic in this country rather than rely on mandatory funding that will not materialize, which is why the subcommittee allocations that will be released in the next few weeks will be so important.

I hope my colleagues on the other side of the aisle will join us in urging an increase for Labor, HHS in fiscal year 2017. And with that, I look forward to your testimony and to our discussion this morning.

Thank you, Mr. Chairman.

INTRODUCTION OF WITNESS

Mr. COLE. I thank the gentlelady.

And now, Ms. Enomoto, you are recognized for your testimony.

OPENING STATEMENT

Ms. ENOMOTO. Well, good morning, Chairman Cole. Good morning, Ranking Member DeLauro and members of the House Appropriations Committee.

I would like to begin by thanking you. Thank you for inviting me here today. Thank you for shining the light on these important issues related to substance use disorders and mental illnesses in this country. And thank you for the tremendous support the committee showed to the Substance Abuse and Mental Health Services Administration in the Consolidated Appropriations Act of fiscal year 2016.

You made important investments in the work that SAMHSA does—helping communities in crisis, confronting the epidemic of opioid overdose, expanding treatment for people with serious mental illnesses, and preventing suicide and substance use among our tribal youth. By doing so, you sent a clarion call to the Nation that behavioral health is, indeed, essential to overall health.

We are honored by your faith in us to do this important work for the Nation, and we are committed to executing your charge with the utmost attention to financial integrity, operational efficiency, and programmatic outcomes. Working together, we will save lives and we will strengthen communities. This is what makes me enjoy coming to work every day.

That is why in fiscal year 2017, we hope to build on the momentum you have provided. The President's budget outlines a \$4,300,000,000 investment in SAMHSA. It is an increase of \$590,000,000. It is also an increase to ensure that every State can implement the full array of science-based services that we know are needed to serve young people just emerging from the fog of a first episode of schizophrenia.

It is an increase that will ensure that every person with an opioid addiction, whether that is heroin, prescription drugs, fentanyl, every person who seeks treatment will find an open door. It is an increase that will help that father, that daughter, that veteran, spouse, or friend to know that help is available and suicide is not the answer.

SAMHSA'S FY17 PRIORITIES

In fiscal year 2017, SAMHSA proposes to focus on four urgent public health priorities for the President, for the Secretary, and I believe for this committee—engaging individuals with serious mental illness into quality care, addressing the opioid crisis, preventing suicide, and maintaining the behavioral health safety net.

We can gain traction on these issues. We have the science. We know how to do it, but we need to get the resources on the ground. The President's budget provides what we need to advance this critical work.

SERIOUS MENTAL ILLNESS

Thanks to expanded coverage provided by the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, over 60 million Americans have access to increased behavioral health—increased access to behavioral health services. Unfortunately, less than half of children and adults with a diagnosable mental illness seek treatment, and for those who do seek treatment, even with the most serious conditions, the delay between first onset and help-seeking can be more than a year.

That is unacceptably long. For conditions as serious and potentially disabling as bipolar disorder, major depression, PTSD, or schizophrenia, every day counts. So to address this gap, the budget proposes a new \$500,000,000 2-year mandatory funding investment to improve access to mental health services and engage people into high-quality care as early as possible.

For SAMHSA, this initiative includes \$230,000,000 over 2 years for evidence-based early intervention services. As I mentioned, this would enable every State to establish one early intervention program. It builds on a body of work by the National Institute of Mental Health, including their RAISE—or their RAISE research initiative that found that coordinated special care delivered early in the course of an illness can decrease future episodes, the likelihood of future episodes of psychosis. It can reduce long-term disability, and it can help people get their lives back on track, which at that age is so incredibly important. It can bend the curve.

So this 2-year program will supercharge the efforts already under way with the mental health block grant 10 percent set-aside for early SMI. To complement this effort, the budget proposes a new 10 percent set-aside within the Children's Mental Health Initiative to focus on youth and young adults at clinical high risk for developing psychosis.

The potential value of this preventive intervention during the prodrome phase when we can actually have a chance to stave off a psychotic disorder is incredible. So SAMHSA proposes to test implementation of this promising approach in community practice settings to foster innovation and take advantage of emerging science to change and even save lives.

Because we know already what can happen when we wait too long. ER visits by individuals in behavioral health crisis have been on the rise for over a decade. They often result in long waits and unnecessary inpatient care. And for too many people with mental illnesses and substance use disorders, they are being seen in ERs. They are being seen in homeless shelters. They are being seen in jail. These are not systems well equipped to meet their needs.

So in fiscal year 2017, we also propose the Increasing Crisis Access Response Effort, or ICARE, program to help communities build and sustain integrated crisis response systems to prevent and mitigate, respond to, and ensure follow-up to behavioral health crises like we see so often in this country.

To complement this effort, we are maintaining funding for the assisted outpatient treatment program that you appropriated to us for the first time in fiscal year 2016. This program will support communities to implement and evaluate assisted outpatient treatment and its impact on health and social outcomes, hospitalizations, criminal justice involvement, homelessness, and other important outcomes for people with SMI.

To advance this program, SAMHSA is partnering with NIMH and ASPE to design and evaluate it. And yet each day, opioid overdoses are claiming the lives of Americans from every walk of life. Whether we live in Oklahoma City; Oakland, California; Oakridge, Tennessee; or Oglala Lakota County, America's obsession with opioid painkillers and illicit drugs poses a major public health crisis.

ADDRESSING THE OPIOID CRISIS

The fiscal year 2017 budget makes a bold commitment to face this challenge head on, a \$1,000,000,000 2-year investment in new mandatory funding to build the addictions workforce and bolster the continuum of services—prevention, treatment, and recovery—to address the opioid crisis. Of the \$1,000,000,000, \$920,000,000 over 2 years will come to SAMHSA for State targeted response cooperative agreements to support community prevention, build the workforce, use telehealth for addiction treatment, and expand the availability of MAT, including needed psychosocial services and recovery supports.

The initiative also includes \$30,000,000 over 2 years for SAMHSA to evaluate the effectiveness of MAT programs under real-world conditions to help identify opportunities to improve treatment outcomes. In addition, on the discretionary side, SAMHSA proposes to double our MAT program, our MAT targeted prescription drug and opioid addiction grants from \$25,000,000 to \$50,000,000, and that would support 23 States, enabling us to reach a total of 46 States with these grants.

And as we expand funding availability to pay for MAT, we have to ask ourselves who is going to provide these services? And that is why we are requesting \$10,000,000 in funds for a buprenorphine prescribing authority demonstration to test the safety and effectiveness of expanding the pool of professionals who might prescribe buprenorphine to include advanced practice providers, such as advanced practice nurses and physician's assistants.

In a parallel effort, SAMHSA is preparing to propose a new regulation to increase the highest patient limit for physicians who already have a waiver to prescribe buprenorphine. And these efforts will complement our ongoing SAMHSA activities, including courses for healthcare professionals on prescribing opioids for pain, enhancement of prescription drug monitoring programs, and expanding access to naloxone, disseminating our—this is our opioid overdose prevention toolkit, which is, in fact, the most often downloaded item on SAMHSA.gov.

PREVENTING SUICIDE

Unfortunately, drug overdose is not our only problem. In 2014, nearly 43,000 Americans died by suicide. Five thousand five hundred of these deaths were among young people under the age of 24. Thankfully, SAMHSA had \$57,000,000 to dedicate to preventing suicide in this vulnerable age group.

By contrast, however, 37,000 deaths occurred among adults over 25. Currently, people ages 45 to 65 and those 85 and older are at highest risk for suicide, yet in fiscal year 2015 and fiscal year 2016, SAMHSA had only \$2,000,000 to address adult suicide prevention, and this was an increase over 2014.

So the 2017 budget proposes—gives us the opportunity to follow a true public health approach and allocate resources to focus interventions where we are losing the most lives. In the case of suicide, that means increasing our focus on middle age and older adults while maintaining our substantial investment in preventing youth suicide.

It is important to note that in our \$30,000,000 proposal for National Strategy for Suicide Prevention, we are including a tribal set-aside of \$5,200,000, and we look forward to working with our colleagues at IHS on the implementation of National Strategy for Suicide Prevention in both SAMHSA and IHS.

MAINTAINING THE BEHAVIOR HEALTH SAFETY NET

Furthermore, the President's budget highlights SAMHSA's commitment to maintaining the behavioral health safety net by continuing to invest in the mental health and substance abuse block grants at \$532,000,000 and \$1,900,000,000, respectively.

Since 2013, the mental health block grant has grown by \$100,000,000, and the substance abuse block grant has grown by \$150,000,000. We appreciate those increases, and they are important gains for us to maintain. As the entire healthcare system pivots to value-based purchasing and delivery system reform, we must maintain funding to ensure a smooth transition for people with mental illnesses and substance use disorders.

The behavioral health safety net provides access to those evidence-based practices not covered by insurance that research has told us are essential to help people achieve and maintain meaningful recovery. At the same time, it is critical to note that the SABG prevention set-aside is the major funding of primary substance abuse prevention in this Nation.

Finally, it wouldn't be a conversation about behavioral health if we didn't talk about workforce development. We must act swiftly to ensure that the behavioral health workforce is sufficient to meet growing demand.

This expanded workforce includes prescribing and nonprescribing professionals—psychiatrists, psychologists, social workers, nurses, counselors, therapists, peers, youth, adults, and families. A skilled and diverse workforce is critical.

Toward this end, we are requesting \$10,000,000 to support peer professional workforce development, and in addition, we will work closely with our colleagues at HRSA and IHS as they implement complementary efforts to expand the number and grow the competency of the behavioral health workforce. We are grateful for the administration's and Congress' support in this crucial area as well.

Members of the committee, thank you for your time. We know all too well that substance use disorders and mental illnesses come at a great cost to society. The impact of untreated or untreated behavioral health conditions on the labor market, criminal justice system, businesses, schools, and communities is tremendous, but above all, the impact is greatest on individuals and families.

Thank you very much for your willingness to talk to me today about this, and I am happy to take any questions.

[The information follows:]



Testimony Before the
U.S. House Appropriations Subcommittee on
Labor, Health and Human Services, Education, and Related Agencies
Hearing on
“SAMHSA’s Fiscal Year 2017 Budget”
March 2, 2016

Statement of Kana Enomoto
Acting Administrator
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

Good morning Chairman Cole, Ranking Member DeLauro, and distinguished members of this Committee. My name is Kana Enomoto, and I am the Acting Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the Department of Health and Human Services (HHS). I am pleased to be here to discuss the \$4.32 billion investment SAMHSA is proposing for Fiscal Year (FY) 2017, a \$590.2 million increase from the FY2016 enacted level.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities. Prevention, treatment, and support to help people recover from mental and/or substance use disorders are essential strategies for the health and prosperity of individuals, families, communities, and the country. Half of all Americans will meet criteria for a mental or substance use disorder during their lives. Yet, data show an alarming lack of the number of individuals who receive treatment for behavioral health conditions. These conditions cost lives, and strain families and resources in the same way as untreated physical illnesses. They cost productivity as a leading cause of disability in the United States, yet the majority of those who need treatment do not receive it. SAMHSA strives to close this gap by raising awareness that:

- Behavioral health is essential to health;
- Prevention works;
- Treatment is effective; and
- People recover.

Now, more than ever, the country needs a targeted and focused approach to address behavioral health conditions affecting so many Americans. Through its FY 2017 budget request, SAMHSA leads public health efforts to advance the behavioral health of the nation by focusing on four key

priority areas: engaging individuals with serious mental illness (SMI) in care, addressing the opioid crisis, preventing suicide, and maintaining the behavioral health safety net.

Engaging Individuals with Serious Mental Illness in Care.

The FY 2017 Budget builds on the Administration's efforts to increase access to mental health services. Through its \$500 million, two-year mandatory funding investment in mental health, the Administration aims to address the nation's mental health crisis proactively and strategically. This initiative includes **\$230 million over two years for Evidence-based Early Intervention Services**, a new formula grant in SAMHSA for all states to establish at least one early intervention program and to enable states that already have such programs to further expand their efforts. This program establishes a minimum dollar amount per state (\$700,000) to provide these services. Evidence shows that engaging individuals with or at risk for serious mental illnesses into care early can reduce the disability associated with mental illness.

The Budget request continues the increased FY 2016 enacted investments in the **Mental Health Services Block Grant (MHBG)**, by providing level funding of **\$532.6 million**, and by maintaining the **MHBG set-aside of 10%** for evidence-based programs which intervene early in the onset of serious mental illness. Although the block grant represents only one percent of all state and federal spending on mental health care in the United States, it provides significant leverage to assist public mental health systems serving approximately 7.6 million adults with serious mental illnesses and children with serious emotional disturbances through flexible funding for services that may not otherwise be available to them.

The Budget also proposes a new **10 percent set-aside (\$11.9 million) in the Children's Mental Health Initiative (CMHI)** to focus on youth and young adults who show symptoms of being at clinical high risk for developing first episode psychosis. Specifically, SAMHSA seeks to develop and implement a services research demonstration effort implementing and evaluating strategies for early intervention during the prodrome phase, the phase in which a disease process has begun but no diagnosis has been made to mitigate or delay the progression of mental illness, reduce disability, and maximize recovery.

SAMHSA recognizes that far too many people who experience a behavioral health crisis are being seen in jails or hospital emergency departments, both ill-equipped to address their needs. ER visits by those with behavioral health conditions have been on the rise for more than a decade and often result in long stays and unnecessary inpatient care. The FY 2017 Budget requests **\$10 million for a new program, the Increasing Crisis Access Response Efforts (ICARE) grant program**, to provide states and communities the opportunity to develop or adopt sustainable, comprehensive, and coordinated community-based crisis response systems for children, youth, and adults with mental health and/or addiction problems. Through the ICARE grants, SAMHSA will address the need to build, fund, and sustain crisis systems capable of preventing and de-escalating behavioral health crises as well as connecting individuals and families with needed post-crisis services to prevent recurrence.

Additionally, the FY 2017 budget request maintains funding for the **Assisted Outpatient Treatment program at \$15 million**. The program aims to help communities use AOT, treatment mandated by court order, to improve health and social outcomes and reduce

hospitalizations, homelessness, criminal justice involvement, and other negative outcomes often associated with serious mental illnesses. This program will include a robust evaluation to measure the impact that it has on those served.

Addressing the Opioid Public Health Crisis

Another major priority for SAMHSA is addressing the crisis of opioid overdose from prescription pain relievers, heroin, and fentanyl. According to the 2014 National Survey on Drug Use and Health (NSDUH) 4.3 million individuals aged 12 and older used non-medical use of prescription pain relievers during the past month and 435,000 reported using heroin.¹ The President's Budget recognizes the need for immediate action and proposes to address the opioid epidemic with a \$1 billion two-year investment in new mandatory funding. SAMHSA is a key player in this initiative, which focuses on three specific areas targeted for their potential to produce the most impact:

- (1) Improving opioid prescribing practices;
- (2) Increasing the use of naloxone; and
- (3) Expanding use of medication-assisted treatment (MAT) and recovery support services for individuals with an opioid use disorder.

Of the \$1 billion in new mandatory funding, SAMHSA proposes **\$920 million over two years** to support cooperative agreements with states to expand access to treatment for opioid use disorders. In each of FY 2017 and 2018, SAMHSA would provide **\$460 million in new mandatory funding toward State Targeted Response Cooperative Agreements** for states to

¹ Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from <http://www.samhsa.gov/data/>

help individuals seek and successfully complete treatment and sustain recovery from opioid use disorders . Evidence-based strategies that states might consider include training and certifying opioid use disorder treatment providers, supporting delivery of MAT, employing telehealth strategies, implementing prevention efforts, developing health information technology systems. Program goals include: reducing the cost of care, expanding access, engaging patients, and addressing the negative attitudes associated with accessing opioid use disorder treatment.

Another component of the Administration's two-year initiative includes **\$30 million in new mandatory funding** for SAMHSA to implement **Cohort Monitoring and Evaluation of MAT**, to evaluate the effectiveness of treatment programs employing medication-assisted treatment under real-world conditions. This program will help identify opportunities to improve treatment for patients with opioid use disorders.

In addition to the new mandatory investments, SAMHSA continues and expands existing strategies to address opioid use disorders. SAMHSA is requesting **\$50.1 million** to double the size of the **Medication Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA)** program. The funding will support 23 new MAT-PDOA state grants in providing FDA-approved MAT in conjunction with psychosocial interventions to those living with opioid use disorders.

To help further expand access to treatment, SAMHSA's Budget Request includes a \$10 million pilot project, the Buprenorphine-Prescribing Authority Demonstration, aimed at increasing the types of practitioners able to prescribe buprenorphine for opioid use disorder treatment, where

allowed by state law. This demonstration will test the safety and effectiveness of allowing prescribing buprenorphine by non-physician advance practice providers.

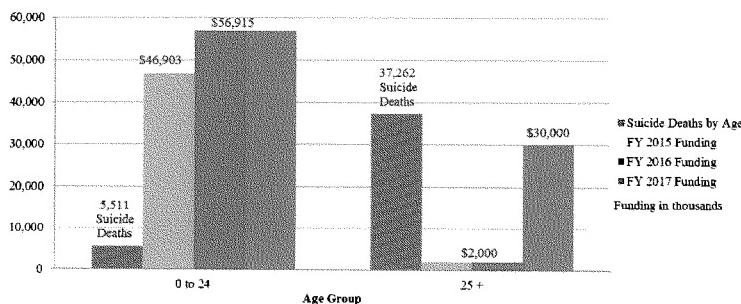
In conjunction with these treatment efforts, SAMHSA is also proposing continued investments to prevent the misuse and overdose deaths related to prescription drugs, heroin, and fentanyl. The FY2017 Budget maintains investments in the **Prevention of Prescription Drug and Opioid Overdose Related Deaths program at \$12 million**. This program focuses on overdose death prevention strategies such as naloxone distribution and education of first responders on its use along with other prevention strategies. Additionally, SAMHSA requests continued support (\$10 million) of the Strategic Prevention Framework-Rx program which enables states to enhance, implement, and evaluate strategies to prevent prescription drug misuse. These continued and expanded efforts build upon SAMHSA's numerous activities geared toward preventing prescription drug and opioid misuse and treating opioid use disorders, including: courses for healthcare professionals on prescribing opioids for pain, prescription drug monitoring program interoperability enhancement, development and implementation of the Opioid Overdose Prevention Toolkit, and clarification on the allowable use of SABG funds to support equipping first responders with naloxone.

In addition, SAMHSA has led the Department's effort to draft a regulation on the limit for physicians that have a waiver to prescribe buprenorphine. As the Secretary noted, the Department's goals in drafting the regulation are to increase access to MAT, ensure the provision of quality care, and, at the same time, prevent diversion. SAMHSA has led this effort for the Department working in close partnership with HHS's Assistant Secretary for Planning and

Evaluation (ASPE). Due to the urgent need to respond to the opioid epidemic, the completion of this draft regulation is a top priority.

Preventing Suicide

In its FY 2017 Request, SAMHSA is also taking a targeted approach to addressing the alarming rates of suicide in the nation. Between 1999 and 2014, the suicide rate in the United States rose from 10.46 to 13.41 per 100,000 people. In 2014, nearly 43,000 Americans died by suicide, making suicide the tenth leading cause of death—above homicide, HIV, opioid overdoses and traffic deaths. Currently, people aged 45 to 65 are at the highest risk for suicide followed by people ages 85 or older, yet many of the current suicide prevention resources focus only on youth and young adults.



Recognizing the urgency of addressing this issue for adults and older adults, SAMHSA is requesting **\$30 million in FY 2017, an increase of \$28 million, to support the National Strategy on Suicide Prevention (National Strategy) including a new Zero Suicide program.** The new effort would build on the National Strategy's recommendation for a comprehensive,

multi-setting approach to suicide prevention. SAMHSA proposes to take a two-pronged approach. First, the program will fund the implementation of the Zero Suicide model in health systems—based on the fundamental premise that suicides that occur while an individual is under care within health and behavioral health systems are preventable. The second component focuses on utilizing a multi-sector approach within communicates to implement suicide prevention strategies. This effort would also include a **\$5.2 million tribal set-aside** to focus specifically on the issue of suicide as it relates to tribal populations.

Maintaining the Behavioral Health Safety Net

SAMHSA also prioritizes maintaining the behavioral health safety net. SAMHSA's Block Grant programs provide critical and needed services and supports to address prevention and treatment of mental and/or substance use disorders. In the FY 2017 Budget Request, SAMHSA continues its investments in both the Community Mental Health Services Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SABG) at \$532 million and \$1.9 billion, respectively.

Other Targeted Investments

In addition to maintaining the significant increases to the MHBG and SABG enacted in FY 2016, SAMHSA is also proposing a \$7.1 million increase to the Project Advancing Wellness and Resilience in Education (AWARE) program. As part of the President's Now is the Time (NITT) initiative to address gun violence, this program raises awareness about mental health issues in schools and communities, and connects young people and their families with services. The additional funding would support a new cohort of State Educational Agency (SEA) awards,

continue existing grants, provide technical assistance to the NITT programs, and support evaluation efforts. Additionally, this funding continues efforts to address communities which have recently experienced civil unrest. SAMHSA has a target to serve over four million children through these programs.

SAMHSA is also requesting \$10 million to support the development of a new Peer Professionals Workforce Development program, which would provide tuition support and further the capacity of community colleges to develop and sustain behavioral health paraprofessional/peer training and education programs. Evidence has found that individuals with a substance use disorder who regularly engage in peer-delivered interventions are more likely to abstain from substance misuse.

Maintaining FY 2016 funding, SAMHSA is proposing a 25% set-aside within the Pregnant and Post-Partum Women demonstration program to test the impact of expanding the range of required and optional family-centered services.

Conclusion

On behalf of SAMHSA, I appreciate the opportunity to testify today and share with you our prevention, treatment, and recovery support strategies to address the nation's critical behavioral health issues. We look forward to working with Congress to implement these goals. I welcome any questions that you may have.

MANDATORY FUNDING PROPOSAL

Mr. COLE. Well, thank you very much for your testimony, and thank you very much for you and your colleagues' professional efforts to deal with what we all agree is genuinely a national crisis. And I think, you know, the subcommittee showed again last year that it is very interested in trying to work with the administration on this.

As you are aware, as I mentioned in my opening remarks, most of the initiatives you are proposing are not within our jurisdiction. Literally, I am mystified by this because there is considerable support for two proposals that the President and the administration generally put forward.

The Cancer Moonshot, we were all out at NIH, or a number of us, earlier this week to discuss that. We want to find a way to work with the administration on that. This initiative, again, we would agree is a very important initiative. But we are simply not going to have the ability to do that.

Do you know, are there any discussions under way between the administration or with the relevant committees of jurisdiction about the mandatory funding issue?

Ms. ENOMOTO. Not that I am a part of, but I do know that the view on the mandatory funding is that it is fully offset by the President's budget and that we are hoping that this can be a down payment or a supercharge to some—some important efforts, some of which are already under way and some of which really need to get jump-started in order to make progress on the important health issues that we are talking about.

FY17 DISCRETIONARY FUNDING INCREASE

Mr. COLE. I am not aware of any either, and I will be in some meetings later today and this week where I will seek to see if that is happening. But in the absence of that, and you know, I think it is very unlikely that that is going to come to pass. I mean, I appreciate the optimism of the administration. But I just—I don't see it. And if I am wrong, so be it.

So given that, you have really only asked us for a \$60,000,000 increase on your discretionary line. Can you tell us how that \$60,000,000 would be used and whether, in your view, that is enough to deal with the problem?

Ms. ENOMOTO. Well, I think we would welcome a conversation about the balance between mandatory and discretionary, as well as the short-term and long-term goals, because I would agree that in order to achieve the goals that we have outlined for ourselves to make sure that everyone who is addicted to opioids who seeks treatment finds an open door. That will take a major infusion of funds.

Mr. COLE. Well, we will keep waiting for that discussion to happen. Maybe you and I will actually be invited to it on some occasion, but the people that I know that are supposed to make those decisions haven't heard anything either at this point.

FUNDING BEYOND MANDATORY PROPOSAL

So let me ask you this because the other challenge that this committee would have—let us assume that this occurred, and we were able to do this for 2 years—we are going to have some sort of fiscal cliff then 2 years down the road.

You won't be here, but unless the voters of Connecticut and Oklahoma change their mind, my ranking member and I may well still be here. So how would we fund those programs?

I don't think you are—I am sure you are not suggesting that in 2 years we could take care of this if we spent \$960,000,000 to take care of it. So those programs then would have to go on, and we have no assurance what our allocation would be, or that is the advantage of building something in the discretionary budget.

Once it is in that budget, there is a very good chance that we may reshape it, we may change it, but that funding stream is going to continue and States can count on it. In my own State, if we were to do something like you suggest here, and we were fortunate enough to win some grants. They are in the middle of a budget crisis themselves right now. So I can promise you they can't pick it up and sustain it.

So we would have set up a program that 2 years down the road, unless we found some other funding source for, would collapse, and how would you address that if you were sitting in our places?

Ms. ENOMOTO. Well, I think the thought behind this is that what we are talking about in the State cooperative agreements is across the spectrum. So it is prevention, treatment, and recovery. So remember that we would be investing in your prevention system so that you would have fewer cases of opioid use disorder knocking on your doors in 2 years.

You would be investing in the workforce so that after the money goes away, you will still have the people who have been trained, who have been certified, who have been given greater access or providing greater access to people who are seeking treatment. And you have invested in a telehealth infrastructure so that you can get—that those professionals who aren't available in rural and remote areas can actually reach folks without a 2-hour drive or a \$50 bus fare to try to get to a service provider that is in a big city.

So I think there are some investments available through these State grants that would actually carry on through the end of—or through into the next phase where things could be picked up by the block grants or could be picked up by third-party payers.

Mr. COLE. Well, that is an excellent point. I have no doubt there would be some residual benefits and carryover, but I still think we would face a problem.

But I can't enforce a 5-minute clock if I don't keep it myself. However, we have been joined by we affectionately call him "the big chairman." Do you want me to give you time to—

OK. In that case, if we can, I will just move to my ranking member for whatever questions she cares to offer.

[Pause.]

Ms. DELAURO. Lovely. Thank you. Thank you very much, Mr. Chairman.

And Mr. Big Chairman, thank you very much.

Ms. Enomoto, last week, I participated in a series of events on drug treatment programs in Connecticut. I was with Michael Botticelli, Director of the National Drug Control Program at the White House, and talking about solutions to this devastating epidemic that we face.

In addition to talking to medical experts and public health leaders about opioid addiction, I talked to families who have the first-hand knowledge of the heartbreak and the havoc that is caused by addiction, and I visited a methadone maintenance program at the New Haven Correctional Center. The message that emerged from these discussions and site visits was that there was a critical need for greater access to treatment, particularly medication-assisted treatment.

Too many individuals don't seek treatment. They can't afford it. It is not available or because of the stigma attached to addiction.

A recent study found that over 80 percent of individuals with opioid use disorders do not receive treatment, with little difference in the rate of treatment during the past decade. You would agree that that has to change.

EXPANDING MEDICATION-ASSISTED TREATMENT AND HEALTH IT

My questions to you on this effort are in the budget. Your budget has a significant new initiative, \$1,100,000,000 over 2 years to address opioid use. How is SAMHSA proposing to expand access to medication-assisted treatment for millions of individuals who are trying to break their habit?

And a second question is your proposal highlights, and you mentioned, telehealth and health IT systems as activities that would be eligible for funding. Can you talk about those activities, both telehealth and health IT, to opioid treatment strategies and your capacity to be able to do that?

EXPANDING HEALTH IT

Ms. ENOMOTO. Thank you very much, Ranking Member DeLauro. Your leadership in shedding light on this issue, your commitment to speaking with families, to visiting our providers, is so greatly appreciated because the scope and depth of the crisis is really measured in human terms.

What we hope to do with our State capacity expansion grants or cooperative agreements would be to ask those States to focus on the communities that are hardest hit by the opioid crisis. So focus on where you have the biggest numbers and address the deaths from overdose and fallout by addressing prescribing practices.

EXPANDING MEDICATION-ASSISTED TREATMENT

Ms. DELAUR. What about the medication-assisted treatment, which seems to be a good road to follow?

Ms. ENOMOTO. Yes.

Ms. DELAUR. How are we expanding that?

Ms. ENOMOTO. Well, we have a number of routes doing that right now. So we have our medication-assisted treatment prescription drug opioid addiction grants that are on the discretionary side. So, again, we went from \$12,000,000, thanks to the committee went to

\$25,000,000 with an increase of \$13,000,000, and now proposing an increase up to \$50,000,000.

So those are already grants targeted to States with the highest rates of opioid admissions, and we are working with States to implement any one of three FDA-approved medications, together with—when we say medication-assisted treatment, that means it is medication plus necessary psychosocial treatment and recovery support services because that is what the science tells us is most likely to get the best outcome.

People with opioid use disorder who have had medication-assisted treatment are most likely to achieve longer-term recovery. So, absolutely, that is what we are doing in the discretionary grant. That is what we are doing by training providers.

We are—under DATA 2000, SAMHSA operates the buprenorphine waiver program with the DEA, and so we have expanded our access—expanded our efforts to provide training to physicians who are interested in providing buprenorphine to their patients. For example, in Scott County, Indiana, we were involved in the response last summer to make sure that we could increase access in the immediate term to help stem the tide of the spread of HIV in that community.

EXPANDING TELEHEALTH AND HEALTH IT

Ms. DELAUBO. Your telehealth and IT stuff, tell me quickly. My time is running out.

Ms. ENOMOTO. So, so as I mentioned, we would want to make sure that providers who are in central areas or urban areas are able to reach those patients who are in either medically underserved or behavioral health underserved areas. They don't have access to a clinician who could prescribe buprenorphine, Vivitrol, or although for methadone, we will still need to—

Ms. DELAUBO. Do you have the capacity to do that?

Ms. ENOMOTO. Not right now.

Ms. DELAUBO. Not right now. Well, I have got 11 seconds. So I will finish up here. Let us go, 10, 9, 8. Okay. Thank you.

Mr. Chairman, thank you. Yield back.

Mr. COLE. Thank you. And thank you for adhering to the clock, and we will certainly have an opportunity to get back to you, I am sure.

So if we can, we have been joined, as you know, by the chairman of the full committee, who has been a national leader in this area and has really, frankly, brought our attention on it and, I think, done a lot to make sure that we were able to do what we did do last year in this area. So, Mr. Chairman, I would call on you for whatever statement you would care to make and then, obviously, any questions you would care to put to our witness.

Naturally, I will extend that same courtesy to our ranking member of the full committee when she arrives, if she can make it. So, Mr. Chairman?

Chairman ROGERS. Mr. Chairman, thank you for yielding. Thanks for the courtesy.

Welcome, Madam Administrator, to your first hearing before the committee in this role.

I will keep my remarks brief. I am pleased that the President's budget recognizes the scope of opioid abuse in America and prioritizes treatment for those suffering from addiction. We have heard it often. We even heard it today. We have more deaths from opioid abuse overdoses than car accidents and growing. It is getting worse every day.

Of the 2.5 million Americans who need treatment for opioid use disorders, less than 1 million are receiving it. That is a serious problem, and we have got to do something about it.

I am pleased that you will be discussing these and other issues at the National Prescription Drug Abuse and Heroin Summit in Atlanta the week after Easter. We look forward to hearing from you at that time down there.

That has become, by the way, the premier organization in the country bringing together the whole gamut of aspects of opioid abuse—treatment, education, recovery, and law enforcement—all in one place. And it is an amazing—this is the fifth annual summit, and we thank you for coming.

It is important to note that there is no one size fits all approach to treatment. We have got to foster a regimen which tailors and personalizes a patient's treatment to his or her individual needs, and certainly medication-assisted treatment are a piece of the puzzle. If provided under the care and supervision of a medical professional trained in addiction, MAT can help a patient turn his or her life around and move forward in a positive direction.

This committee has repeatedly communicated to SAMHSA that there is a full spectrum of options that we ought to be considering for every patient who walks through the door looking for help, and doctors ought to be trained in all of them to decide what is best for that particular patient. Unfortunately, I am not sure that message has been received.

If the chairman will indulge me, let me ask a few brief questions.

UTILIZING NON-OPIOID MEDICATIONS

Buprenorphine has been a useful tool for many doctors, but it seems that HHS and SAMHSA have held this drug up as a silver bullet, focusing on prescribing caps and access to it. However, there are also non-opioid medications available to treat patients struggling with addiction, and our committees encourage you to look at these products as another tool in the box. Are you making progress on looking in that toolbox?

Ms. ENOMOTO. Absolutely. We recently issued a guidance on the use of long-acting injectable naltrexone and strongly believe that all patients, that this is a decision between patients and their clinician. And so all three options for medication-assisted treatment for opioid use disorder should be available.

And we have actually received guidance previously. So we are doing a thorough review of our technical assistance materials regarding medication-assisted treatment and updating them to make sure that we are inclusive of all the FDA-approved medications, including antagonist and agonist therapies. And so we absolutely agree with you that there are multiple pathways to recovery and that antagonist therapies are often the right choice for people.

ABSTINENCE-BASED TREATMENT

Chairman ROGERS. Medication-assisted therapies may not work for everyone. So what will you do to ensure that faith and community-based abstinence treatment programs have a space in the big picture as well?

Ms. ENOMOTO. You know, since 2005, SAMHSA led in the space of recovery support services and the engagement of faith and community-based organizations in the provision of both clinical care and recovery support services. Through that program, we have served thousands of Americans and helped them achieve long-term recovery.

Then we have since then rolled recovery support services into what is expected to be provided under the substance abuse prevention and treatment block grant, and we have also worked with the Centers for Medicare and Medicaid Services to better understand how recovery support services provided by traditional providers or faith-based or community providers can be supported by third-party payer.

So we are looking for the inclusion because we have seen with our data that people can and do recover when they receive services that resonate with them in different ways, and particularly providers from a shared faith or other kind of community can reach people in ways that touch them very deeply.

EXPANDING ACCESS TO TREATMENT IN RURAL AREAS

Chairman ROGERS. Cities have facilities that rural areas do not, and rural areas are really, really hurting because they just simply don't have the capability to deal with it. I have spoken on a number of occasions with Secretary Burwell about the importance of access to treatment, especially in rural communities.

How would your budget proposal address the shortfall of residential facilities in rural parts of the country?

Ms. ENOMOTO. Well, as I mentioned earlier, one of the aspects of the opioid proposal would include the use of technology, and I think that can be done in multiple ways. One way would be through traditional telehealth. So we can get providers who are located in cities who would be able to connect one-on-one with an individual who is located in a rural area.

Another way is through a collaborative care model, such as Project ECHO, where we can get experts who are located at academic centers or advanced practice centers, provider organizations who can convene on a regular basis and provide training, support, supervision, and collaborative case management with providers who are located across the country. So sometimes there are providers who would be willing to see a person with a substance use disorder, simply don't have that specialty training or that expertise, but with the support of an expert who is available to them on a regular basis, they can actually manage that kind of complex care.

And there is research to show that this works on all kinds of conditions from depression to hepatitis to cancer care, diabetes. And we also know that it can work for substance use disorders as well.

Chairman ROGERS. Well, thank you, Madam Administrator, for the hard work you are doing. We will see you in Atlanta.

Mr. COLE. Thank you, Mr. Chairman.

I am going to move to my good friend from California, Ms. Roybal-Allard, for 5 minutes. And then, if I may, I am going to ask my friend, the vice chair of the committee, to take the chair while I go to another hearing, and I will be back at some point.

Thank you.

[Pause.]

UNDERAGE ALCOHOL CONSUMPTION

Ms. ROYBAL-ALLARD. Acting Administrator Enomoto, I have a hearing conflict today. So I want to apologize in advance for having to leave right after this round of questions, and I will be submitting several others for the record.

But I wanted to take a few minutes to talk with you about a bipartisan issue that I have been working on with Congresswoman DeLauro for over 15 years, and that is the issue of underage drinking in this country. Ten years after passage of the Sober Truth on Preventing Underage Drinking, it is clear that the STOP Act's comprehensive approach is making a difference.

According to the 2015 Monitoring the Future survey, alcohol use by 8th, 10th, and 12th graders are at their lowest level in decades. SAMHSA has been a great partner in the fight against underage drinking by leading the ICCPUD, producing the annual report, and administering the community grants, and the progress we have made is very, very encouraging.

But sadly, as you know, underage alcohol consumption in the United States remains a widespread and persistent public health and safety problem. And the most recent Monitoring the Future survey tells us that alcohol is still the number-one drug of choice among our youth.

So I have been working very hard with Congressman Mike Fitzpatrick and Congresswoman Rosa DeLauro to reauthorize the STOP Act so its critical programs will continue into the next administration, and I am hoping that all my committee colleagues will join me in this effort.

2015 STOP ACT REPORT

But in the meantime, I wanted to ask you about your plans for the fiscal year 2017 STOP Act programs. When do you expect to release the 2015 report on the STOP Act?

Ms. ENOMOTO. So, Congresswoman Roybal-Allard, first let me start by saying thanking you for making the time to be here today and thank you for your and Congresswoman DeLauro's incredible leadership on the issue of underage drinking prevention. It has been—it has yielded real results for our country that is saving lives and creating safer families, safer communities for everybody.

I want to make sure that I get you complete and accurate information about the fiscal year 2015 report. So I would have to get back to you with your staff.

Ms. ROYBAL-ALLARD. Okay. I would appreciate that.

Ms. ENOMOTO. Absolutely.

Ms. ROYBAL-ALLARD. Because I think the reports have been very, very valuable.

Ms. ENOMOTO. Absolutely. Happy to do that.

UPCOMING ICCPUD MEETINGS

Ms. ROYBAL-ALLARD. Also, will you convene the ICCPUD principals and stakeholders meeting one last time before this Congress and administration ends, and when will that take place?

Ms. ENOMOTO. March 31.

Ms. ROYBAL-ALLARD. March 31, that is great. And the reason I am happy to hear that, because those meetings have been extremely valuable in evaluating the conversation about underage drinking prevention and encouraging high-level strategizing and coordination of the best ideas and practices to achieve that goal. So that is very good news.

FY18 STOP ACT GRANTS

Evaluation of the STOP Act community grants have twice shown their success in lowering underage drinking rates in participating communities. In fiscal years 2015 and 2016, SAMHSA awarded 97 grant continuations, but your budget justification states that you will award 79 new STOP Act grants. Will you also be proposing new grants in fiscal year 2018 to help meet this backlog of community seeking STOP grants?

Ms. ENOMOTO. I would—I think that depends on the grant-making cycle. So I am sorry I don't have the fiscal year 2018 data. I do know that we are planning to award 80 grants in fiscal year 2016. Happy to follow up and get you the 2017 and 2018 data.

Ms. ROYBAL-ALLARD. OK. I appreciate that. And also do you know what the backlog was of all those that had applied for grants? How many were you not able to—

Ms. ENOMOTO. Oh, how many—how many were unfunded—

Ms. ROYBAL-ALLARD. Yes.

Ms. ENOMOTO [continuing]. And fundable? I am sorry. I don't have that data, but happy to get that to you.

Ms. ROYBAL-ALLARD. OK. My time up? No? OK.

Mr. WOMACK [presiding]. You still have the better part of a minute left.

Ms. ROYBAL-ALLARD. OK. Well, then I just want to close by saying it seems to me the STOP Act programs are a perfect example of a small Government investment yielding a huge return in behavior change and subsequent improved health, and communities who have STOP Act grants are showing significant improvement in underage drinking rates, and more and more communities each year are recognizing underage drinking prevention as a priority.

So I thank the chairman and my colleagues for continuing to support and fund the STOP Act.

Mr. WOMACK. Next we will move down to the other end of the dais, and the gentleman from Virginia is recognized. Mr. Rigell?

Mr. RIGELL. I thank the chairman.

And thank you, Ms. Enomoto, for being here today, for your testimony.

And let me first say that we share a common commitment to reducing substance abuse and improving mental health. With that

said, I want to walk us through just a couple of things that concern me.

And so if I think of Congress in some ways as playing a role of board of directors here, if we come at things from a I hope it is a constructively critical approach to these questions, the first is that I want to associate myself with the remarks of the chairman, Chairman Cole, when he talked about his objection to increasing the number of accounts that are placed in the mandatory side. I have found in my 5-plus years here that the institution, this institution, and then even collectively with the administration, we have been unable thus far to make any substantial progress on reforming the mandatory side.

One could argue that we have made—it has been rough, but we have reduced the discretionary side. So just as an American concerned about our fiscal trajectory, I couldn't support that.

Also I have always questioned the wisdom of the grant program generally, and I am not saying I am in opposition to all grants. But I fail to see the wisdom oftentimes of taking money from citizens in a State, sending it to DC, and then having other fellow Americans decide, you know, they will develop a program and then have fellow—their fellow citizens then again compete for that money. And to get the money, they have to shape their State's programs and bend it to the will of DC.

ADMINISTERING GRANTS TO STATES

So there are some things that are absolutely essential, can only be done at the Federal level. I get that. But what is the inherent wisdom and logic of when you meet men and women who have education equal to your own, are also subject matter experts in the States, and yet we believe that it is the wisest course is to bring the money up and then have to reallocate it?

And indeed, some States don't get any of that money, or they don't get as much as others, and it is inherently inefficient if for no other reason every time you meet, every time you have a memo, every time you promulgate directors, it is not money going to help a mentally ill person. So help me with that philosophically, Okay?

Ms. ENOMOTO. So at SAMHSA, less than 10 percent of our overall appropriation goes to administrative costs, such as salaries or rent or overhead, and 90 percent of our money does go back out to States and communities. And over half of that money goes directly to States through the block grants.

So I agree with you that it is—it is the States and the communities who can best decide what is useful to them. At the same time, if you follow a public health model, it is not necessarily the wisest course of action to put an equal amount of money everywhere because the problems are not distributed equally. And so when we—just in a basic infectious disease model or even with a chronic disease model, you want to focus on where those diseases are striking the hardest or where you have an evidence-based practice that has the greatest opportunity to make traction to bring it down, to reduce risk, or to stop spread.

And so, I think that is the value that the Federal programming does add, as well as I think the Appropriations Committee setting priorities for us. You identify problems that are key to this Nation,

to the health of the Nation, to the health of families, to the health of the economy. And I think you allocate funding to us in ways—in places where you see the greatest need, and that is how we then turn it back to the community.

Mr. RIGELL. I thank you for your answer. I just would be careful. You know, I would just be cautious in terms of trying to tighten up how much more is put into those programs versus just let the States, you know, invest in the areas that they think directly, keep the taxes as low as they possibly can.

There is just a natural sense. I think Mr. Jefferson, you know, talked about it, President Jefferson. But just this natural tendency for government to grow. It is just a natural tendency of the beast.

SAMHSA'S HIGHEST EFFICIENCY PROGRAM

But I have 25 seconds left. I am going to give you an easy one here. Of all the programs that you think need investment, among them, which is the one that shows the most promise in terms of efficiency per dollar?

Ms. ENOMOTO. I think our proposal for expanding access to medication-assisted treatment is very efficient. We have—again, we have the data. We have strong data that shows that if you provide these interventions, you can—you can help people achieve recovery. You can reduce the risk of overdose death, and you can increase public safety, reduce the risk of transmission of HIV. There is value in so many different places there.

Mr. RIGELL. Thank you.

And I thank the chairman.

Mr. WOMACK. Welcome to the hearing. It is great to see you. My question is going to be centered around targeted capacity expansion grants, and I appreciate your review of SAMHSA's plan for reversing the ongoing epidemic of opioid abuse. Our Nation has successfully faced other public health epidemics in the past, and with your partnership, we will hopefully put an end to this one as well.

Excessive use of opioids has been identified by a number of Federal agencies. We all know that CDC has raised it, the CMS, Veterans Health Administration, and all are taking measures to prioritize non-opioid alternatives for pain management.

These other Federal agencies are actively working to reduce the overprescribing of opioids because opioids are associated with overdose deaths, addiction, drug diversion, and the rising incidence of newborns requiring opioid withdrawal management, all very serious public health concerns. And I share Chairman Rogers' concern about that and commend him for his leadership down through the years. He has been a real leader on that front.

Unlike other agency efforts to prioritize the use of non-opioid alternatives for the management of pain, SAMHSA seems to prioritize the use of opioids, especially buprenorphine, for the treatment of opioid addiction, even though there are non-opioid alternatives that are evidence-based and approved by the FDA.

Under targeted capacity expansion, both the fiscal year 2016 House and fiscal year 2016 conference reports directed the Center for Substance Abuse Treatment to use medication-assisted treatments for two specific purposes—to achieve and maintain absti-

nence from all opioids and heroin and to prioritize treatment regimens that are less susceptible to diversion for illicit purposes.

TARGETED CAPACITY EXPANSION GRANTS

Specifically, two questions. And I will give you both questions, and then you can take the time necessary to answer. Specifically, how is SAMHSA planning to address these two conditions that were placed on targeted capacity expansion grants? And when will the RFA for these grants be released, and will it reflect the direction that Congress gave to SAMHSA in the appropriations bills?

And I will yield to you for the answer.

Ms. ENOMOTO. That is actually very easy. So the funding announcement is not yet out, but it will be out prior to March 15th is the expectation. And absolutely, we plan to reflect the directions that we received in the report language, that we will be prioritizing those medications that are less susceptible to diversion, and we will be encouraging our grantees or focusing our grantees on achieving those interventions which can lead to abstinence.

So that is the easy part. We appreciate your investment, your time, your attention, and we listen well. So, and I guess I want to maybe just a point of clarification that in terms of non-opioid alternatives for the management of pain, SAMHSA actually has PCSS, so Physician Clinical Support System, that provides technical assistance to providers as they are considering prescribing opioids for pain management, as well as for the substance use disorder treatment.

And that work absolutely includes alternatives, both alternative pain management strategies that are not opioid based, as well as alternative—or not even alternative, but the full spectrum of addiction treatment options—with medication, without medication, agonist, and antagonist. So I think we are trying to follow the science and trying to give the people of this country who have opioid use disorders access to the best treatment available, and that means for different people different pathways to recovery.

Mr. WOMACK. Thank you. And I still had a minute left. So, no, I am going to yield to the gentlelady from—oh, I am sorry, the gentlelady from California since Ms. DeLauro has already gone once.

So, Ms. Lee, the floor is yours.

Ms. LEE. Well, thank you very much. I apologize for being late. I had another hearing, but I am really happy to see you here, and thank you for your testimony.

I am, by profession, a clinical social worker. So I am really aware of how—the role that you play in terms of substance abuse and mental health services. I am pleased to see the increase in attention to drug addiction, but it is not a new one. Heroin has been around for a while.

In the 1980s, when the crack epidemic ravaged African-American communities, addicts were, you know, thrown into jail, right, and cast off as moral failure thugs.

And so as substance abuse has evolved, now we are faced with a new look at this drug addiction, especially through heroin addiction and opioids. And I hope that you had a chance to read this article, New York Times article, “When Addiction Has a White Face.”

Because I don't want to see us make the same mistakes that we made in the past where we were, you know, ending up putting people—we have lost a whole generation of African Americans and Latinos because we did not put resources into rehabilitation. We put people addicted to drugs into jail, okay?

REDUCTION IN CRIMINAL JUSTICE ACTIVITIES

Now this budget in some ways is really troubling because there is a large cut to your criminal justice activities program that work to address the epidemic, the drug epidemic in communities of color. So how are you going to coordinate with the Department of Justice and other agencies to develop a comprehensive strategy to ensure that drug offenders are provided with treatment rather than being thrown in jail with this budget cut?

I think you request a \$16,100,000 cut to the criminal justice activities. Yet, you know, the increase for addressing heroin and opiate addiction has grown. And I don't want you to rob Peter to pay Paul because we need to be able to treat everyone and provide alternatives in terms of rehabilitation and not cut one and put—one account and put money in the other.

Ms. ENOMOTO. Thank you very much for that question, and it is a very important topic to focus on.

The good news about our criminal justice line and the reduction that we are taking there is that it will not—it will not entail the elimination or the reduction of any current grants. So we will be able to continue the portfolio that we have, the grants that we have, and I think we have a very robust program, a very robust partnership with the Department of Justice already. We work very closely with OJP, with OJJDP, BJA, and we are in lockstep with them as we look for alternatives to criminal justice and as we—

Ms. LEE. Well, how does this happen with the \$16,100,000 cut in this budget? How are you going to keep doing—we need to do more in the criminal justice system's budget, not less.

Ms. ENOMOTO. I appreciate that, and we—we recognize that we cannot—we cannot jail our way out of this problem. You are absolutely right. We have to find ways to get people into treatment. We hope that our continued criminal justice involvement—criminal justice portfolio will help to do that for many Americans.

Ms. LEE. Well, we do, too. But there is a \$16,100,000 cut in this proposed budget.

Ms. ENOMOTO. Right.

Ms. LEE. So I am trying to figure out how that is going to happen.

Ms. ENOMOTO. Well, because of the cycle of some grants ending and the availability of funds in fiscal year 2017, we would be able to continue our current portfolio so no grants would be cut. I am not sure if we might still be able to do actually a small number of new grants still, but not as much as we—as we would have if we didn't have to take the cut.

MINORITY AIDS PROGRAM

Ms. LEE. OK. I hope this committee can look at that because, once again, you are looking to cut \$6,700,000 from the minority AIDS program, OK? And systematically, across this budget, I see

cuts that are going to impact communities of color, which have been disadvantaged and disproportionately hit by a lot of what we are trying to address now and provide some equity. And you are cutting all of these programs.

And so how do you intend to address the minority AIDS program in a way that we are going to move towards seeing an AIDS-free generation? And when HIV and AIDS heavily impacts minority communities, and yet you are cutting \$6,700,000 there.

Ms. ENOMOTO. I think on the HIV, we are trying to keep a top-line number of HIV that is the same in MAI. But that it is a balancing between our substance abuse and our—

Ms. LEE. Huh? It is cut by \$6,700,000.

Ms. ENOMOTO. That doesn't plus up?

Ms. LEE. Well, I thought the minority AIDS budget in this budget was cut. If not, I stand corrected, but I would like to verify that. Do you have that?

Staff, could I ask you, is there a cut? Is that accurate? OK. So, so we believe that there in this budget is—I don't have it in front of me, but we think that there is a \$6,700,000 cut to the SAMHSA's minority AIDS program.

Ms. ENOMOTO. So, so if you look over on the mental health appropriation, so the minus 6.7 is offset by a plus 6.7 in the mental health appropriation.

Ms. LEE. OK, but it is in the mental health?

Ms. ENOMOTO. For minority AIDS because we know that both the mental health and the substance use problems are so important to people with or at risk for HIV that we are trying to have a balanced approach that lets us look at both mental health and substance abuse together for people with or at risk for HIV.

Ms. LEE. OK. Well, thank you, Mr. Chairman. I would like to pursue that a little bit more.

Mr. WOMACK. I thank the gentlelady.

BEST PRACTICES IN CRIMINAL JUSTICE ACTIVITIES

Back to me. You know, I appreciate what you said just a minute ago about we can't jail our way out of these problems. Just curious, is there some State, some agency, some group, some organization doing a better job in, say, within the criminal justice framework around our country that seems to probably have not broken the code, but at least established some best management practices and/or alternatives to the incarceration of people addicted?

Is there—can you point to anybody around the country that we should be more like?

Ms. ENOMOTO. You know, I had the opportunity to talk with the National Organization of Correctional Health Systems a few months ago, and I heard actually community after community, warden after warden coming up, talking about here is how the drug court in our community has reduced our census, and we are seeing more and more people returning to health, returning to their families and not adding to our rolls.

And so I think there are a number of communities where you can see that and happy to put you in touch with them. I am sure there are some in your State or in your district. But we have also seen the criminal justice system, the correctional system, police, jails be

engaged with the naloxone issue, doing amazing work to make sure that we have our first responders equipped to reduce—to reverse overdose when they come upon it, as well as educated to understand the nature of addiction as a disease and the benefits for the individual and for the community and for public safety to get that person into treatment rather than move in a rush to incarcerate.

So I think there are a number of communities around the country that we could point to.

Mr. WOMACK. So, but you mentioned specifically drug courts, and I agree. I think there are many effective drug courts going on, including my district, that are reasonable approaches and alternatives. Are there any other types of alternatives aside from drug courts within the community frameworks out there that you are beginning to see are paying some dividends on this front?

Ms. ENOMOTO. Oh, yes. So in our—we have a strategic initiative on trauma and justice, and so in that initiative, we are looking at a sequential intercept model. So there are six different points in the potential engagement with the criminal justice system, criminal and juvenile justice system, that there are opportunities to intervene. So that includes things like crisis intervention training for police officers, includes things like reentry programs for people that are going back into the community.

So I think all along the points in the continuum, there are promising practices and evidence-based practices that can bring down the burden of mental illnesses and substance use disorders in that population.

BEHAVIORAL HEALTH IN SCHOOLS

Mr. WOMACK. What about our schools?

Ms. ENOMOTO. As it relates to, for example, is it expulsion the problem that—

Mr. WOMACK. The identification of problems, the—you know, I know there are some schools that probably would like to wish the problem away or pretend that the problem doesn't exist. Are we doing a better job in our schools identifying either those at risk or those obviously so afflicted?

Ms. ENOMOTO. Oh, absolutely. And I think that is what you will see in our Now is the Time proposal, Project AWARE. That is exactly what you describe. It is a partnership.

We worked very closely from the inception of the proposal to the execution of the program with the Department of Education, as well as OJJDP, to make sure that we are connecting school districts, schools, families, community-based organizations, law enforcement, as well as the behavioral health system, so that we are raising everyone's awareness. We are introducing evidence-based practices to change school climate, as well as to help people increase their mental health literacy and so that teachers can identify teachers and other staff and other students, and community members can identify those children who are most at risk for mental illness or might be showing signs of a mental illness.

And then making sure that we are making those warm handoffs. So that instead of going to jail, instead of getting expelled, a child might get access to an assessment or to a counseling or to actual services if they actually have a disorder.

ALTERNATIVES TO INCARCERATION

Mr. WOMACK. All right. So here is a softball in my last 20 seconds. An individual, particularly a young individual, that has a substance abuse-type disorder, with proper treatment, we can make that individual, instead of an incarcerated person because of a lot of other crimes that are a manifestation of the underlying problem, but we can turn that individual into a productive citizen and give them the self-esteem back, reengage them with their families, and make it a victory, could we not?

Ms. ENOMOTO. Absolutely. Some of my best friends and closest colleagues are people in long-term recovery, and I have the highest esteem and the highest ambition for what is possible for people.

Mr. WOMACK. I thank the gentlelady.

Ms. DeLauro.

Ms. DELAUR. Thank you very much, Mr. Chairman.

And just two comments on some of your comments. One, the last point is that, oftentimes, we take a look at this issue, particularly with young people, and that the answer is incarceration. The answer is not incarceration. The answer is treatment.

And secondly, with regard to communities, I point to New Haven, Connecticut. I was at the correctional center, as I said to you, and they are dispensing methadone. And there is a line of people there. They put their ID up there. They get the methadone. They take the orange juice afterward because it is so bitter tasting.

I then had the chance to talk to those folks, and this is providing them with this medication-assisted treatment program, which you are putting your emphasis on, which is the direction in which to go in. What I have found, though, in my conversations with these folks is that, in fact, yes, they are ready to go out and they are ready to leave, and many of them do not have a job. Many of them don't have a home. So they wind up back on the street and without employment because they can't get employment because no one wants to hire them, and then we are back in the cycle again.

So those are—that is the realities of what we are dealing with here.

INCREASING ACCESS TO NALOXONE

I have two questions. One is with the access to naloxone. Pharmacies are beginning to dispense it without an individual prescription. It greatly expands access to a lifesaving drug that reverses the effects of an opioid overdose.

Access is increasing, but the price is increasing as well for naloxone. The omnibus, we provided SAMHSA with \$12,000,000 to help high-need communities mitigate overdosing, including training and equipping first responders with naloxone.

How will the rising cost of naloxone impact the amount of naloxone your grantees are able to purchase? What can we do to increase access to naloxone? Should the program be expanded to other communities? In addition to first responders, do community-based organizations have affordable access to naloxone?

Ms. ENOMOTO. So I would acknowledge that the pricing of prescription medications is sort of outside of our authorities. However,

you are correct that as the price goes up, with a fixed amount of money, people can't buy as much.

Ms. DELAUBRO. OK.

Ms. ENOMOTO. We agree that it is important to increase access to naloxone, and while we defer to physicians and their patients in terms of what the individual decision is in terms of the prescribing of naloxone, in our opioid overdose toolkit, we talk about the practice of co-prescribing for those patients who are at greatest risk for overdose, that we want to make sure that naloxone, we know it works. But it doesn't work if you don't have it.

And so we need to make—we are looking at opportunities to educate providers about the naloxone and its lifesaving value and to ask them to have those conversations with their patients to decide whether or not that is the right thing for them if they are getting prescriptions of opioids.

Ms. DELAUBRO. Well, we ought to take a look at how we can make it more accessible and do that in a way, since we know what it does. And instead of looking at a whole bureaucracy, we ought to just figure out the best way to do it and what are the resources to be able to get to community organizations the training that is necessary, to pharmacists, et cetera, get them trained and get them to dispense it so that we can mitigate against this crisis.

Overall with mental health, this is a very big issue for me. Surgeon General's report, mental illnesses in this country are more common than cancer, diabetes, or heart disease. It affects people of all ages, income, gender, ethnicity.

ACCESS TO MENTAL HEALTH CARE

Many of the most serious mental illnesses—bipolar, schizophrenia—occur in childhood and adolescence. One half of all chronic mental illness begins by age of 14. Three quarters by age 24. Suicide is the second-leading cause of death for ages 15 to 24 years old. Staggering statistics.

And the statistics regarding treatment for mental illness are just as staggering. In 2013, almost 50 percent of children ages 8 to 15 with a mental illness received no mental health services. Rates are not much better for adults, with 40 percent receiving no treatment.

This is cost effective if we deal with this in our society, and the barriers include cost, availability, and, yes, stigma. Let me ask you this. Do we have the systems and the capacity in place to care for a significantly larger number of children and young adults if we are successful in getting them referred for treatment?

If not, what is it going to take us to build that capacity? Talk to us about the shortages of mental health providers. How large are those shortages? Are they increasing? Which professions are most effective? What other strategies are available for increasing the number of mental health professionals?

Ms. ENOMOTO. That was a lot of questions.

Ms. DELAUBRO. A lot of questions. [Laughter.]

Mr. WOMACK. That is a lot of stuff. We are going to give you about 30 seconds.

Ms. DELAUBRO. Mr. Chairman, I would hope with so few Members here that we can allow more than 30 seconds. I think the chairman would be happy to do that, and I request that of you, if I might?

These are critical issues, and we don't have any other Members here. It is just the three of us.

Mr. WOMACK. A reasonable time, but I was about to yield to Ms. Lee, and we are already 30 seconds into her time. So we will get there.

Ms. DELAURO. I think Ms. Lee would bear with me. Thank you, Ms. Lee. Thank you.

Ms. ENOMOTO. Thank you, Ranking Member DeLauro.

I think you are again on point about the—the distressing lack of access for so many children and adults with mental illness to services, and the need to expand, the demand to expand we hope will be assisted by the Affordable Care Act and the Mental Health Parity and Addiction Equity Act. More people will have ways to pay for services. Twenty million people insured, thanks to the ACA.

At the same time, there are barriers. There are barriers because people don't know where to go to care—get care. And people don't think they can afford care, and people are afraid of what other people might think of them if they—if they do receive care or they have a diagnosis.

And I think all of those, the negative attitudes, finding out—helping make care more affordable, helping make sure that care works for everybody, and helping all Americans understand that taking care of your mental health, treating an addiction is no different from treating any other chronic condition or medical illness.

Do we have the workforce to do it now, to treat everybody who needs it? No. I mean, we are fairly busy as we are, and we are only seeing half of the people with a mental illness, 1 out of 10, maybe 2 out of 10 people with a substance use disorder. So were everyone to walk in the door tomorrow, we don't have enough providers. We don't have enough professionals. We don't have the infrastructure.

That being said, we do have the science. We have the technology. We have the will. I think we have the ability to get there. But as I said earlier, we need to get the resources on the ground.

Ms. DELAURO. It would appear to me that we don't have the resources to get us there.

So thank you very much, Mr. Chairman.

Mr. WOMACK. Ms. Lee.

MINORITY AIDS PROGRAM

Ms. LEE. Thank you, Mr. Chairman.

That is the point. The budget of this subcommittee is woefully, way, way, way too low to meet the needs of your agency and to meet the needs of the American people. That is the point.

Let me go back now to the cut in the Minority AIDS Initiative. It is being cut, the \$6,700,000, from the substance abuse account. Now that doesn't make much sense to me because when you address HIV and AIDS, you have got to address, yes, the mental health needs of those living with the virus, but you have also got to address this in a comprehensive fashion, which means substance abuse.

So you can't cut from the substance abuse account and put it into the mental health account, and then cut the criminal justice substance abuse program also. Because what you are doing is in many

ways, you are vamping on minority communities with these cuts, with people who have issues around substance abuse.

And so, for the life of me, I can't figure out why you would rob Peter to pay Paul because that is what it is doing. We need that \$6,700,000 restored into this account, as well as the mental health services.

Ms. ENOMOTO. Thank you, Congresswoman.

I couldn't agree with you more that we need a comprehensive approach to help people who have HIV/AIDS. I just had the opportunity to participate in a PEPFAR visit in South Africa, where we saw people struggling mightily at the center of the epidemic there. And I will tell you that the population at great risk, the population of young women that we are focused on with PEPFAR is at risk not only because of substance abuse, but also because of mental illness.

If we cannot help manage people and their substance use, if we cannot help—help people manage their substance use, if we cannot help people manage their depression, their PTSD, it is very hard for us to make sure that they get tested, they know their status, that they are on ART and that they are managing nondetectable—to a nondetectable viral load.

And so that comprehensive approach is what we are trying to achieve. I am happy to work with you on a way that we can do that—

Ms. LEE. Yes.

Ms. ENOMOTO [continuing]. That doesn't disadvantage those communities who are the most vulnerable.

Ms. LEE. Yes, and so let us find the \$6,700,000 somewhere else, Okay?

SYRINGE SERVICES PROGRAM GUIDANCE

Secondly, as it relates to the entire syringe exchange issue, I co-chair the HIV/AIDS Caucus with Congresswoman Ileana Ros-Lehtinen. It is a bipartisan caucus. And I am pleased that this budget provides a bit more flexibility on how Federal funds can be used to support syringe exchange programs, which are a critical, once again, continuum of substance use services and an important bridge to treatment.

So how are your plans written to incorporate this flexibility across its grants and cooperative agreements, including the substance abuse prevention and treatment block grant?

Ms. ENOMOTO. I think we are preparing to issue guidance to States with our colleagues at CDC in coordinated fashion to all the States that, once again, they are able to use their Federal funds for syringe exchange programs and happy to see that this strongly evidence-based public health intervention is once again available.

Ms. LEE. Thanks very much because it is really remarkable progress. But the progress only began when this epidemic got out of hand. I believe it was in Indiana, and your Governor, the Governor was bold enough to say, you know, syringe exchange really can help mitigate against this terrible disease.

So thank you very much.

Thank you, Mr. Chairman.

Mr. COLE. [Presiding] Thank you very much.

And as you know, I just arrived back. So, Mr. Womack, have you had an opportunity to ask some questions?

Mr. WOMACK. I have had a couple of opportunities, and I will take another one.

Mr. COLE. Well, I will give you that opportunity while I get myself reoriented here. Thank you.

TRANSLATING RESEARCH INTO EVIDENCE-BASED PRACTICES

Mr. WOMACK. Absolutely. Ma'am, we often hear about the time lag between translating research into practice. It can take years for those suffering from a mental illness to receive treatment based on research evidence.

What efforts is SAMHSA taking to ensure the evidence-based practices learned from research is reaching those who work most directly with individuals suffering from a mental illness? In addition, is there a feedback loop in place between researchers and practitioners where practitioners provide potential areas of research to SAMHSA, and SAMHSA puts those ideas forward for consideration?

And then as you ponder the answer to that, let me reflect back on a trip that our chairman took us on this week to the National Institutes of Health, and one of the more impressive things I have seen in a while was a discussion about the use of ketamine as a treatment protocol for mental illness, suicide prevention, and a person who has been immensely helped by this trial. And so trying to figure out how long does it take for us to get from something that we now believe is beginning to work in a trial to actually effective use in a protocol that can be in place?

In this particular case, Mr. Chairman, what struck me as odd was the fact that in this case, the individual had to go across country to get the treatment. The treatment or the vial for treatment was a very small—like a dollar, but yet the infusion, if you will, was thousands of dollars.

So help me break this down and understand why we can't do something faster and more cost efficient when it concerns something as serious as that.

Ms. ENOMOTO. Those are several great questions. Thank you very much.

I agree with you that shortening the time from bench to bedside or research to practice is absolutely essential. That is why we are so excited about both the early serious mental illness set-aside as well as the prodrome proposal.

So for early serious mental illness, FEP, you have a well-established intervention or a set of interventions that have already been tested by NIMH in community practice settings that we are ready to take to scale, and that is a very short time. These RAISE trials and the RAISE papers have only just come out in the last few years, and so that is a very quick turnaround, a very quick scaling up.

On the prodrome side, the NAPLS study, the North American Prodrome Longitudinal Study, and NAPLS—NAPLS 1, NAPLS 2—those are still, we are just getting those findings. We are still at the preliminary stages of the findings, and yet we are already pro-

posing this pilot program in our CMHI because the sea change that is possible with this kind of intervention.

So it is early, but the potential to change the lives, to keep someone from actually getting a diagnosis of schizophrenia, what kind of impact could that have? It is incredible, the potential of that, it saves a life. It saves a family.

And so we are proposing to make that investment, put that down payment into adopting, taking the chance to do something innovative.

EVIDENCE-BASED PRACTICES

The challenge that you rightfully point out is because we don't always do that. There are a number of interventions that are strongly evidence-based that we don't see used with widespread adoption, and there are some other innovations, which were not available to test readily. I think that is something that I would be happy to work with you on.

But it is a challenge of the way this process works because on the one hand, you know, we get—we get encouraged to do things that are evidence-based or things that we have done before. And then we sometimes have challenges if, well, "What is the evidence base behind this? What is the evidence base behind that?" When we are really trying to do something that is new or that is emerging.

And so it is that balance between practice-based evidence, you know, the provider saying this is what is working for us now. And not just providers, but also communities, tribal communities would say this is indigenous practice. We have 1,000 years of evidence.

Or where a community of color that has done an adaptation of something that has been working for them. How do we help that make its way into the mainstream system? How do we wrap ourselves around that?

So we have—we are really excited that at SAMHSA, we re-launched our National Registry for Evidence-Based Programs and Practices, and in that, we did two things that are relevant to your question.

One thing is that we asked—we asked our stakeholders—we put it out for open comment and voting—what are the areas that we should be focused on? So give us that feedback. What is the feedback of what are the science-based interventions that you want to see on this registry?

And if the public identifies things, we will go look at the research literature, and if it is there, we will start running it through so that we can examine whether or not these interventions should be on the registry. If it is not there, we can message that back to the institute, saying our providers, our consumers, our advocates, our family members, people in recovery are telling us that they want to see evidence-based interventions in this space, and we don't have it yet.

At the same time, we built a learning center, and that gives us space for those model developers or those communities that say we have a promising model. We have got something that is innovative, and we would like to find out if there is someone who wants to evaluate it. Is there a researcher that we can get matched up with

that is interested in testing this out and helping us take it to the next level?

Because while there is a list as long as my arm of interventions that have a good evidence base that we need to get out more, it is not enough to do everything that we need to do because mental health and substance use disorders touch so many parts of our lives.

Mr. WOMACK. Thank you.

Mr. COLE. Thank you. I am going to take a quick point of personal privilege here. I have been informed by our ever-capable staff that it is my ranking member's birthday today.

Ms. DELAUBO. Yes.

Mr. COLE. And you know, Steve and I could give you a stirring rendition of the Boehner birthday song, but we are on television, and we don't want to subject you to that, nor ourselves to the ridicule that comes. So happy birthday.

Ms. DELAUBO. Well, thank you very, very much. Thank you, Mr. Chairman. Thank you for that.

Mr. WOMACK. Happy birthday, Rosa.

Ms. DELAUBO. Thank you very much.

Mr. WOMACK. Good to have you.

Ms. DELAUBO. I am trying to forget some of them these days.
[Laughter.]

Mr. COLE. Well, you know, only you would be dedicated enough to be interested in talking about suicide and drug abuse on your birthday. I mean, it just tells you something about your devotion, and I mean that in all sincerity. You couldn't have a better person to work with.

Let me, if I may, Madam Secretary, just ask a couple of quick questions in areas that I am very interested in your efforts to refocus SAMHSA on the most at-risk groups and some of the things you have been doing to identify those groups and refocus the agency.

ZERO SUICIDE PROGRAM

In particular, I would like to hear about your Zero Suicide program and your tribal set-aside.

Ms. ENOMOTO. Thank you very much for that question.

So the Zero Suicide program is one that has some very solid data behind it. We have seen that health systems have—many people who end up dying by suicide have been seen within the last month by a primary care provider. Many people who are admitted who receive a—or are admitted for a suicide attempt are the ones who actually complete suicide.

And we have seen in a number of systems, like the Henry Ford Health System in Michigan, that they can by collecting the data of suicide attempts and suicide, death by suicide, by ensuring that there is follow-up to individuals who have been admitted, that there is immediate follow-up and a connection to community services, that there are evidence-based interventions. Evidence-based interventions not just for treating depression, but for actually addressing the suicidality.

If we do I think it is about six different activities, we know we can reduce a suicide rate within a fixed system by 50 percent, 75 percent, 80 percent. These are real numbers that we have seen.

We have seen them in White Mountain Apache Tribe, who have done an outstanding job of setting up a monitoring system and providing these interventions and training. Training providers, community members about the signs and symptoms of suicide and the ways to respond adequately and then making sure that those connections happen, and there are warm handoffs.

And that there is follow-up, there is follow-up because people who end up—who complete suicide often have been touched very recently by our system. So that is what we are hoping to do with that.

We will do a Zero Suicide that is focused in the health system, and then we are looking at ways to do comprehensive multi-sector community approaches as we know prevention, with so many things, it is you can't just prevent it once. Or you can't just do preventive intervention once. It has got to be over time and across systems, and that is what we hope to do.

And we would like to work—we will work with IHS, who also has a Zero Suicide initiative. That will be focused in the IHS facilities, and I think we are going to use our funding working with IHS to figure out how do we wrap this around in whole tribal communities?

TRIBAL SUICIDE PREVENTION

Because, as you know better than I do, that this is such a tremendous problem not only among tribal youth. It is terrible and is tragic among tribal youth, but we recently had our SAMHSA Tribal Advisory Council, and they said we are seeing this in our youth, but we are also seeing it in our middle age and older adults. It is growing. It is a growing problem.

And there is a will. I think people want to do this. We have our tribal behavioral health grants. Those do both suicide prevention and substance use prevention. They allow tribes—and we have a thank you for the expansion of that. We are up to \$25,000,000 and 100 new grants this year to tribes.

And we are really focusing on having community-defined outcomes so that the tribe says this is the outcome that is meaningful for us. This is the outcome that we commit to be accountable for, that we are going to deliver on to SAMHSA. Because so often, we hear from tribes is that you have these prescribed outcomes with data that we don't collect or systems that we don't have or outcomes like homelessness that don't really exist in our community because that is not how we are structured. And so you are measuring us on things that aren't meaningful.

And we are committed to working with the tribes to identify those things that—because then you get into this negative cycle of holding them accountable for things that don't mean anything to me, and then taking away funding. And that is not what we want to do.

At the same time, we take seriously our responsibility as responsible stewards of the Federal taxpayer dollar, and so you know, we are going to work with the tribes to say this is what you want to

do, this is how you are telling us you are going to do it, and this is how we are going to be in agreement about the accountability for the use of these funds. But we want them to be able to find a sustainable and meaningful way to address the dual problems of suicide and substance use in the community.

Mr. COLE. Well, I do want to commend you very much for the efforts in this regard. It is a unique population. And particularly reservation based, it is very different than any place else. And there is a lot of often, as you would know, I mean, some of these reservations are very bleak in terms of quality of life and facilities.

At the same time, there is a connection between people that is also very unique, and there ought to be a way we can do a better job. But I really want to commend you and commend the administration through you for making a special effort here.

With that, let me move to my good friend the ranking member. Ms. DELAURO. Thank you, Mr. Chairman.

CHILDREN'S MENTAL HEALTH

I would commend to you, and I know it is level funded, but it is something called the National Child Traumatic Stress Network. And it is level funded at \$47,000,000. But this is a program that provides trauma services for over 48,000 kids and adolescents. It trains over 200,000 individuals.

And I would just submit to you that I think that what we ought to do is to look at that program as an expansion with regard to the reservations. And specifically with regard to reservations, given the nature of the serious problems that exist there because of environment or certain circumstances.

So after Sandy Hook and the Umpqua Community College tragedy, we started to take a look at what we might do in these areas to protect our kids. So I am heartened by the \$15,000,000 funding for Now is the Time, for that initiative.

And I am concerned, however, the program allows for, as you know, access to mental health services for children and young adults. I am concerned that the increase is being offset by eliminating the youth violence prevention program and cutting in half the budget for primary and behavioral healthcare integration.

Your budget includes \$10,000,000 for new peer professional workforce development, increasing the number of trained peers working with young people 16 to 25, particularly at community colleges. Tell us a little bit more about the program, how it complements your Healthy Transitions program, which is focused on 16- to 25-year-olds.

And by cutting youth violence prevention and the primary behavioral health center healthcare integration, what are we losing since the need, in my view, I think you might agree, is still there. So—

[Pause.]

Ms. ENOMOTO. Forgive me. I am trying to make sure I am getting that all down. It is a very rich question. Thank you.

First of all, with the National Child Traumatic Stress Initiative and its potential value to tribes, we do have tribal grantees within the National Child Traumatic Stress Initiative. That network has been responsible for the development and promulgation of evi-

dence-based practices for dealing with complex trauma in American Indian and Alaska Native youth.

It is—it really is a national resource. The network is a national resource with incredible experts, incredible providers and provider groups that are really moving the field ahead not only for the United States, but for the world. And so I appreciate the contributions of the NCTSI across its diverse portfolio.

With respect to our peer workforce proposal and how that dovetails with Healthy Transitions, it is, together with the Minority Fellowship Program and the Behavioral Health Workforce Education and Training program, those are all part of the Now is the Time workforce proposals, which we continue to believe strongly are added value to the Nation's behavioral health system.

In addition to that, and I wanted to note I think to an earlier question about the different types of providers and where they are and what is valuable, we are partnering with the Health Resources and Services Administration on a behavioral health workforce research center so that we can do a better job, and I can get you better data on exactly the questions that you are asking me. But if you have to ask me, all the providers are good, and they are all necessary because we know that interdisciplinary, multidisciplinary treatment teams and recovery teams, prevention teams, that is what works.

But, so we think that the peer workforce component is so critical. For one thing, work is recovery. I think it has been mentioned. People get out of jail. People get out of the hospital. If they don't have a purpose, then it is very hard to get galvanized for everything else that needs to happen.

So that and the peer workforce is a complement to the professional workforce. It is not a replacement. It is not an either/or. But what we hope to do is to start building a career ladder by partnering with community colleges and States to get certified, a certified peer workforce established so that that can become a regular part of the behavioral health workforce to complement the clinical professionals that are trained in other professional schools.

Ms. DELAUBRO. Youth violence?

YOUTH VIOLENCE AND CHILDREN'S MENTAL HEALTH

Ms. ENOMOTO. Youth violence, that is obviously a very sharp observation. The Safe Schools/Healthy Students program is what was funded out of the youth violence line for over a dozen years. In over a dozen years, we saw tremendous outcomes in terms of reduction of violence, school violence, perceptions of violence, increased referrals to mental health services, and reduced substance use among youth, and perceptions of safety, increased perceptions of safety for teachers and students.

So the Safe Schools/Healthy Students model was fantastic. But in those dozen years, we never got a State that implemented the Safe Schools/Healthy Students model statewide, and so that is why we went to Project AWARE with the State. We had a pilot early on the youth violence line. We had a State educational agency grant, and then in Project AWARE, we really went to scale, where we are trying to scale up this intervention that we know works, this model.

So I think actually the elimination of the youth violence line is an effort for us to be, again, those responsible stewards to reduce two lines that are sort of duplicative and doing so much of the same thing and that we are trying to consolidate those resources into one place because we think that that Project AWARE model, which came out of Now is the Time really is the next level of where Safe Schools/Healthy Students was.

Ms. DELAURO. Thank you.

Ms. ENOMOTO. And PBHCI, I just have to say the—we have enjoyed the success of that program for a number of years. We are seeing very positive outcomes in terms of improving both the health status and the behavioral health status of people with serious mental illness by bringing those primary care services—the screenings, the smoking cessation, the blood pressure checks—into the mental health center.

And with this reduction, the very positive news is, is that we don't have to eliminate or reduce any grants to do that. And we will continue to make use of the great work of that program and our Center for Integrated Health Solutions.

Ms. DELAURO. Thank you.

Mr. Chairman, I am going to take my last couple questions and submit them for the record because at 11:45 a.m., I have to—I have to be someplace else. So I will—this is one on primary prevention.

Mr. COLE. Well, we would hardly deny somebody on their birthday something that they requested.

Ms. DELAURO. And the Medicaid screening of children and adolescents and what we are doing to work with CMS on that. But I will submit those.

Ms. ENOMOTO. Happy birthday.

Mr. COLE. I will actually follow your example. I have got a couple things that I wanted to ask and will follow up with you.

But you have been very generous with your time, and we appreciate it very much.

I am sorry. As you know, we have a lot of hearings going on, and Members are having to come and go and cover different things. But we appreciate all the excellent work. We really do.

We appreciate the bold initiative because I think it is a genuine crisis. We want to find a way to help you if we possibly can, but we will have that talk about mandatory funding because I kind of doubt that is going to be the way.

But anyway, it is something on a bipartisan basis I know we all feel strongly about. So thank you again, and thank your team for being here.

The hearing is adjourned.

Questions for the Record from Chairman Tom Cole for the Substance Abuse and Mental Health Services Administration

- 1. Question:** The opioid epidemic has so many facets from targeting prevention, access to treatment, support for families, capacity building for communities, engaging physicians, and educating law enforcement – can you describe your approach and how that aligns with the funding increases you requested? How can we be confident we are targeting the key drivers to change the course of the epidemic?

Response: The Secretary recognizes the scope and complexity of this epidemic, and is taking comprehensive, immediate action to address it. For this reason, the FY17 Budget requests a \$1 billion two-year investment in new mandatory funding. SAMHSA is a key player in this initiative, which recognizes the need to spread resources across the spectrum in order to address comprehensively the opioid epidemic.

The State Targeted Response Cooperative Agreement, a proposed \$460M component of this initiative, allows states to identify and address needs in myriad areas which respond to the opioid epidemic. These areas include: prevention, the provision of medication-assisted treatment and other clinically relevant treatment, recovery support services, workforce development, health information technology, and the use of telehealth strategies. The breadth of activities supported by this program evidences the understanding that this problem cannot be fixed by focusing on a single area alone. This proposal is also enhanced by the recognition of the need to evaluate medication-assisted treatment to ensure individuals receiving care are obtaining the best possible treatment. This evaluation will be done through the proposed \$30M Cohort Monitoring and Evaluation program.

Other key areas in SAMHSA's Budget enhance these strategies and reflect a commitment to addressing the Secretary's commitment to address this issue. This commitment focuses on three specific areas targeted for their potential to produce the most impact to change the course of the epidemic:

- (1) Improving opioid prescribing practices;
- (2) Increasing the use of naloxone; and
- (3) Expanding use of medication-assisted treatment (MAT) and recovery support services for individuals with an opioid use disorder.

To improve prescribing practices and help prevent opioid misuse, the FY2017 Budget requests continued support (\$10 million) of the Strategic Prevention Framework-Rx program which enables states to enhance, implement, and evaluate strategies to prevent prescription drug misuse. This program, new in FY16, allows states to enhance the use of data from PDMPs by identifying communities by geography and high-risk populations, connect patients to treatment resources, and complement CDC's Prescription Drug Overdose:

Prevention for States program, which has a component that focuses on using PDMP data to inform the prescribing behaviors of practitioners.

SAMHSA has also addressed the issue of prescribing practices through various efforts related to increasing Prescription Drug Monitoring Program (PDMP) interoperability among states and intra-operability across the PDMP, electronic health records (EHR), health information exchanges and pharmacies. The Enhancing Access to PMDPs Project was funded by SAMHSA and managed by the Office of the National Coordinator (ONC) in collaboration with SAMHSA, CDC, and ONDCP. SAMHSA also funded the PDMP EHR Integration and Interoperability Cooperative Agreement program in Fiscal Year (FY) 2012 and the Electronic Health Record and PDMP Data Integration Cooperative Agreement in FY 2013. These programs bring funding directly to states to complete integration projects.

Another core aspect of the Secretary's initiative is to provide guidance on opioid prescribing practices focusing on inappropriate or excessive prescribing. Recently, CDC released the *Guideline for Prescribing Opioids for Chronic Pain*, to educate prescribers on the appropriate prescribing of opioids to improve pain management and patient safety. SAMHSA supports CDC in this effort and will help disseminate and encourage uptake of the new guideline.

In support of the Secretary's second priority area, preventing overdose-related deaths through expanding the availability and use of naloxone, SAMHSA's FY17 Budget maintains investments in the Prevention of Prescription Drug and Opioid Overdose Related Deaths program at \$12 million. This program aims to reduce the number of prescription drug/opioid overdose-related deaths and adverse events by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone to first responders.

Finally, SAMHSA plays a leading role in the Department's efforts to expand substance use disorder treatment to the millions of Americans who need it. Medication-assisted treatment (MAT) is an evidence-based substance use disorder treatment protocol, and SAMHSA supports the right of individuals to have access to FDA-approved medications under the appropriate care and prescription. SAMHSA also recognizes that not all communities have access to MAT due to a lack of physicians who are able to prescribe and oversee clients using anti-alcohol and opioid medications. To help further expand access to treatment, SAMHSA's Budget Request also includes a \$10 million pilot project, the Buprenorphine-Prescribing Authority Demonstration, aimed at increasing the types of practitioners able to prescribe buprenorphine for opioid use disorder treatment, where allowed by state law. This demonstration will test the safety and effectiveness of allowing prescribing buprenorphine by non-physician advance practice providers.

In addition, the FY17 Budget continues and expands existing strategies to address opioid use disorders. SAMHSA is requesting \$50.1 million to double the size of the Medication Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA) program. The funding will support 23 new MAT-PDOA state grants in providing FDA-approved medications in MAT in conjunction with psychosocial interventions to those living with opioid use disorders.

These continued and expanded efforts build upon SAMHSA's numerous activities geared toward preventing prescription drug and opioid misuse and treating opioid use disorders, including: courses for healthcare professionals on prescribing opioids for pain, prescription drug monitoring program interoperability enhancement, development and implementation of the Opioid Overdose Prevention Toolkit, and clarification on the allowable use of SABG funds to support equipping first responders with naloxone.

2. **Question:** It seems like every day we see events on the news reminding us of the consequences of untreated individuals with serious mental illness. What steps are you taking to help those who suffer from a severe mental illness and what procedures are in place to alert law enforcement should there be signs a person poses a danger to themselves, his or her family, or the community?

Response:

SAMHSA prioritizes the treatment needs of people with serious mental illnesses (SMI). Over three-quarters of the agency's mental health budget is dedicated to serving those with SMI. The Mental Health Services Block Grant and the Children's Mental Health Initiative comprise over half of SAMHSA's mental health programs and target adults with SMI and children with serious emotional disturbances.

Since 1992, the Community Mental Health Services Block Grant (MHBG) has distributed funds to 59 eligible states and territories and freely associated states through a formula based upon specified economic and demographic factors. The MHBG distributes funds to eligible states and territories for a variety of services and for planning, administration, and educational activities. These services and activities must support state-developed plans for comprehensive community-based mental health services for children with serious emotional disturbances and adults with serious mental illness.

Services funded by the MHBG include: outpatient mental disorder treatment for serious mental illnesses, such as schizophrenia and bipolar disorders; supported employment and supported housing; rehabilitation services, crisis stabilization and case management; peer specialist and consumer-directed services; wrap around services for children and families; jail diversion programs; and services for vulnerable populations (e.g., persons who are homeless, those in rural and frontier areas, military families, and veterans).

Together, SAMHSA's mental health and substance abuse block grants support the provision of services and related supports to approximately eight million individuals with mental and substance use conditions. With an estimated 9.6 million (4.1 percent) adults having a severe mental illness in the past year, 43.7 million adults having any mental illness in the past year, and another 24.6 million (9.4 percent) adults with illicit drug abuse in the past month in 2013,²⁹ demand clearly outpaces the public behavioral health system's established capacity.

Starting in FY 2014 Congress established the Set-aside for Evidence-based Programs That Address Needs of Individuals with Early Serious Mental Illness. States were required to set-aside five percent of their MHBG funds to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders. This

was increased to 10 percent in FY 2016. Each year, additional funds were added to the block grant to offset the amount of the set-aside.

The majority of individuals with serious mental illness experience their first symptoms during adolescence or early adulthood, and there are often long delays between the initial onset of symptoms and receiving treatment. The consequences of delayed treatment can include loss of family and social supports, reduced educational achievement, disruption of employment, substance abuse, increased hospitalizations, and reduced prospects for long-term recovery.

The set-aside allocated to states is consistent with the block grant formula and supports implementation of promising models that seek to address treatment of serious mental illness at an early stage through reducing symptoms and relapse rates, and preventing deterioration of cognitive function in individuals suffering from psychotic illness. SAMHSA has collaborated closely with the NIH's National Institute for Mental Health in providing guidance and technical assistance to states regarding effective programs funded by this set-aside.

Under Section 223 of the Protecting Access to Medicare Act of 2014, SAMHSA was authorized to develop criteria that states would use to certify community behavioral health clinics (CCBHCs). The Criteria requires CCBHCs to develop coordination of care agreements with community agencies such as hospitals and law enforcement, and to work together to ensure that protocols for the involvement of law enforcement are in place to reduce delays for initiating services during and following a psychiatric crisis.

SAMHSA will be accepting applications for fiscal year (FY) 2016 Assisted Outpatient Treatment Grant Program for Individuals with Serious Mental Illness (Short title: Assisted Outpatient Treatment [AOT]). This 4-year pilot program is intended to implement and evaluate new AOT programs and identify evidence-based practices in order to reduce the incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and interactions with the criminal justice system while improving the health and social outcomes of individuals with a serious mental illness (SMI). This program is designed to work with families and courts, to allow these individuals to obtain treatment while continuing to live in the community and their homes. This pilot program was established by the Protecting Access to Medicare Act of 2014 (PAMA), Section 224, that was enacted into law on April 1, 2014. SAMHSA has consulted with the National Institute of Mental Health, the Department of Justice, the HHS Assistant Secretary of Planning and Evaluation and the Administration for Community Living on the FOA.

SAMHSA encourages behavioral health and law enforcement agencies to establish protocols to coordinate how they communicate and interact. SAMHSA has supported the communities to improve how their law enforcement agencies and personnel respond to individuals who have serious mental illnesses.

In 2013, SAMHSA issued a grant funding opportunity entitled "Law Enforcement and Behavioral Health Partnerships for Early Diversion." The grants support police and

behavioral health agencies to develop effective partnerships to divert adults with serious mental illnesses and co-occurring substance use disorders appropriately from the criminal justice system and into community-based service alternatives.

The President's FY 2017 Budget includes a new \$115M formula grant program to support early serious mental illness interventions with a plan for \$700,000 minimum allocation to states in addition to the funds provided by a 10% set aside from the Mental Health Block Grant. This program builds on the NIMH program Recovery After Initial Schizophrenia Episode (RAISE) model which has been shown to reduce symptoms and improve quality of life for those served. Significant delays in the identification and treatment of SMI are common; for example, research has repeatedly found that individuals with psychosis often do not receive appropriate treatment for that condition for over a year. This delay in treatment worsens long-term outcomes for people experiencing these conditions affecting their behavioral health, physical health, and achievement of education and employment goals.

The FY 2017 Budget also requests \$10.0 million for a new crisis systems program. This includes \$5.0 million in the Mental Health appropriation and \$5.0 million in the Substance Abuse Treatment appropriation. The Increasing Crisis Access Response Efforts (ICARE) grant program will enable communities to develop a more integrated response capacity to individuals who are in emotional crisis. The absence of a coordinated crisis response system has placed significant pressure on law enforcement and emergency room personnel who are responding to public safety and health situations without the benefit of a coordinated system to successfully prevent, manage, and follow-up. The grant supports planning activities to develop the necessary infrastructure for a comprehensive crisis response system including the engagement of community partners such as law enforcement and behavioral health agencies and other community support organizations.

3. **Question:** Could you describe your agency's efforts to ensure full implementation of the assisted outpatient treatment program for individuals with serious mental illness? Specifically what consultation has occurred between representatives from the National Institute of Mental Health, the Department of Justice, the Administration for Community Living, and the Substance Abuse and Mental Health Service Administration (SAMHSA)?

Response: SAMHSA has been working diligently on fully implementing the new grant program on Assisted Outpatient Treatment. SAMHSA has held multiple conference calls and meetings with staff from the National Institute of Mental Health, the Department of Justice, the Administration for Community Living, and the HHS office of the Assistant Secretary of Policy and Evaluation (ASPE) to discuss the project.

Discussions included consultation on the development of the grant announcement and the evaluation. SAMHSA staff developed a draft grant announcement that was sent to staff at the National Institute of Mental Health, the Department of Justice, the Administration for Community Living, and ASPE for input. Two rounds of calls for comments were held and comments received. Comments were reviewed, clarified as needed, and incorporated into the grant announcement. In addition, SAMHSA is consulting with NIMH, as well as ASPE, on the evaluation design, funding for the evaluation, and the evaluation timeline. The grant announcement is expected to be released in April 2016.

- 4. Question:** How is SAMHSA going to utilize portions of the proposed \$400+ million dollars to address opioid abuse to contend with the rampant opioid problem in Indian Country?

Response: The Strategic Prevention Framework for Prescription Drugs (SPF Rx) grant program provides an opportunity for states, U.S. territories, pacific jurisdictions, and tribal entities that have completed a Strategic Prevention Framework State Incentive Grant (SPF SIG) to target the priority issue of prescription drug misuse. The program is designed to raise awareness about the dangers of sharing medications and educate pharmaceutical and medical communities about the risks of overprescribing to young adults. SPF Rx will also raise community awareness and bring prescription drug abuse prevention activities and education to schools, communities, parents, prescribers, and patients. In addition, SAMHSA will track reductions in opioid overdoses and the incorporation of Prescription Drug Monitoring Program (PDMP) data into needs assessments and strategic plans as indicators of the program's success.

In addition, the Grants to Prevent Prescription Drug/Opioid Overdose-Related Deaths (PDO) are open to applicants who are state governments, including the District of Columbia, U.S. territories, Pacific jurisdictions, and the Red Lake Band of the Chippewa, that receive the Substance Abuse Prevention and Treatment Block Grant (SABG). The purpose of this program is to reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone to first responders.

In addition to the Opioid-specific initiatives, the proposed \$30 million for the Tribal Behavioral Health (Native Connections) grant program supports suicide prevention, substance abuse prevention, trauma related, and mental health promotion activities, which may include efforts to prevent opioid use and abuse.

- 5. Question:** How is SAMHSA planning to utilize the Tribal Behavioral Health Agenda that SAMHSA and the Indian Health Service are developing to guide its fiscal decision-making and allocations to Indian Country?

Response: The National Tribal Behavioral Health Agenda (TBHA) was developed in response to tribal leaders' concerns about behavioral health issues impacting their communities and the disparate and inconsistent culturally appropriate responses across federal agencies to their communities' needs.

Over an 18 month period, SAMHSA and IHS engaged with tribal leaders, tribal behavioral health professionals, tribal community members (including urban Indians) and federal agencies with collaboration by the National Indian Health Board. Various venues around the country provided opportunities to listen to tribal priorities and solutions related to healing from historical and intergenerational trauma; addressing behavioral health from a socioecological perspective; ensuring support for both prevention and recovery; addressing behavioral health services and systems; and, facilitating efforts to raise awareness and visibility around the behavioral health issues impacting tribal communities.

It was acknowledged early in the listening and consultation sessions that no single federal agency, state entity, or tribe can overcome the tremendous behavioral health challenges alone, that federal agencies need to work differently with tribes, and tribes have cultural wisdom that must be taken into account to more effectively address the behavioral health needs of their communities.

The TBHA is a blueprint to guide policy, programs, and practice that takes into account tribal priorities—it presents multiple opportunities to improve SAMHSA's work with tribes and its use by federal agencies, states, tribes and stakeholders will vary. SAMHSA has already initiated a review of its Strategic Initiatives which guide its policies, programming, and funding decisions and identified objectives which correspond with the foundational elements, priorities, and strategies in the draft TBHA. This analysis will allow SAMHSA to identify opportunities to strengthen:

- Efforts to address trauma for tribal grantees across grant programs;
- Prevention, early intervention, outreach, and recovery support for tribal grantees across grant programs;
- Expectations for collaboration within tribal projects and with federal partners on specific programs, where feasible, to promote socioecological approaches to addressing local behavioral health challenges;
- Collaboration with IHS on suicide prevention and other behavioral health funding to leverage resources and reduce administrative burden.
- Collaborations with tribes, tribal organizations, and federal partners to improve: (a) the availability of data and information on the behavioral health of local tribal communities; (b) support joint campaigns to improve awareness and knowledge on culturally appropriate ways to support well-being; and, (c) access to behavioral health services.

The TBHA will also influence current SAMHSA staff training on working with tribal governments, primary needs in provision of technical assistance, communications with Indian Country, and content in funding opportunity announcements. The SAMHSA Tribal Technical Advisory Committee (TTAC) was the initial group of tribal leaders to convey that a behavioral health agenda that included the voices of Indian country was needed. SAMHSA will continue to work with the TTAC on areas where the TBHA can improve AI/AN behavioral health work.

6. **Question:** The president's budget proposes level funding of \$30 million for the Tribal Behavioral Health Grant program. What are your plans to utilize these funds to best combat suicide, workforce development, substance use or the other behavioral problems in

Indian Country? How are you going to ensure that these funds are being used to meet the highest needs?

Response: The Tribal Behavioral Health (Native Connections) grant program will help grantees reduce the impact of substance use disorder and mental illness, and foster culturally responsive models to reduce and respond to the impact of trauma on American Native/Alaska Native (AI/AN) communities through a public health approach. Grantees will mobilize SAMHSA's Strategic Prevention Framework (SPF), a five-step planning process to guide the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities. Through the SPF process grantees will assess needs, identify gaps, and develop a plan. Additionally, grantees may assess their community's behavioral health improvement readiness level using a Community Needs Assessment or a Community Readiness Assessment, and create a Community Resource/Asset Map as deemed necessary. These steps will ensure that grant funds target the grantee's highest area of need in the areas of substance use prevention and mental health, including suicide prevention and trauma.

The grantees will develop policies and procedures to promote coordination across youth-serving agencies. The policies and procedures developed by the grantees to implement the following: standards of care for suicidal young people, processes for helping young people transition into care from one agency to another, the role of local traditional healing/helping practices in supporting suicide prevention among young people and their families, and the role of western/clinical mental health practices in supporting suicide prevention among young people and their families.

Also, this grant will allow AI/AN communities to support youth and young adults as they transition into adulthood by the communities having the ability to utilize the results from conducting a "Service Delivery Systems" analysis, a Community Needs Assessment, a Community Readiness Assessment, and creating a Community Resource/Asset Map. SAMHSA currently projects awarding over 90 new Tribal Behavioral Health grants in addition to the 20 grants that are now in their second year of funding. These grants will be used to develop and implement an array of integrated services and supports designed to reduce the impact of mental and substance use disorders and complex trauma and to prevent suicide. The grants will involve AI/AN community members in all grant activities, assess community needs and strengths related to preventing and reducing suicides and substance abuse among tribal young people, assess needs, identify gaps, and develop a plan that the tribe will pilot in subsequent years of the grant.

Grantees must provide assurances that they will identify and connect the behavioral health services organizations that exist in their community, identify the gaps, and develop and pilot a plan to fill the gaps, address behavioral health conditions that affect learning in the Bureau of Indian Education (BIE) schools, and lead efforts to improve coordination among mental health, trauma, suicide prevention, and substance abuse prevention services for tribal young people and their families. Grantees will use strategies that have been shown to be effective or promising in Native communities, with the option of also using innovative activities that relate to the goal of reducing the impact of trauma, reducing or preventing suicidal behaviors, preventing substance use and misuse, and promoting mental health. Tribes will work with SAMHSA's Tribal Training and Technical Assistance Center, which will help grantees meet

the goals of the grant and provide opportunities to learn with and from other tribes in this grant program.

Grantees must meet specific expectations that address community needs and complete and submit a community needs assessment if an assessment has not been completed within 18 months prior to award. Among several expectations listed in the grant funding announcement, grantees must:

- Assess community needs and strengths related to preventing and reducing suicides and substance abuse among tribal young people.
- Assess needs, identify gaps, and develop a plan that the tribe will pilot in subsequent years of the grant. If an assessment has not been conducted in the 18 months prior to award, grantees will be required to assess their community's behavioral health improvement readiness level using a Community Needs Assessment, a Community Readiness Assessment, and create a Community Resource/Asset Map. In the case of a consortium of tribal organizations, each participating area will be required to conduct a Community Readiness Assessment as part of this grant program.

7. Question: Could you tell us more about SAMHSA's efforts to disseminate information on pain management strategies and how they relate to prescription drug abuse and prescribing practices?

Response: CDC will release the *Guideline for Prescribing Opioids for Chronic Pain*, to educate prescribers on the appropriate prescribing of opioids to improve pain management and patient safety. SAMHSA supports CDC in this effort and will help disseminate and encourage uptake of the new guideline.

SAMHSA has also collaborated with the American Society of Addiction Medicine, Case Western Reserve University School of Medicine, Boston University School of Medicine, and an independent panel of experts in medical education, pharmacology, pain management, regulation, and addiction, to create in-person and online courses for providers. The courses focus on best practices and evidence-based clinical protocols for the use of opioids in the treatment of chronic pain. Specific topics addressed through lectures and case discussions include: 1) chronic pain treatment options; 2) patient selection and risk assessment; 3) patient monitoring, including state prescription drug monitoring programs; 4) clinical issues such as pain relief and overdose risk; and 5) why, when, and how to stop prescribing opioids and pursue other treatment options.

To date, nearly 10,000 physicians and other health professionals have completed a live course offered at one of 64 sites in 40 states and DC. For FY 2015, there were 245 participants in the live CME courses. In addition, more than 64,000 clinicians have received CME/CE certificates for online CME courses SAMHSA has supported. Collaboration with national provider organizations has also resulted in CMEs being provided to dentists on safer opioid prescribing. SAMHSA also funds the Provider's Clinical Support System for Opioid therapies (PCSS-O), which is a national training and mentoring project developed in response to the prescription opioid overdose epidemic. The consortium of major stakeholders and constituency groups with interests in safe and effective use of opioid

medications offers extensive experience in the treatment of substance use disorders and specifically, opioid use disorder treatment, as well as the interface of pain and opioid misuse. PCSS-O makes available at no cost CME programs on the safe and effective use of opioids for treatment of chronic pain and safe and effective treatment of opioid use disorder. To date the PCSS-O has trained over 1,000 clinicians in evidence based pain management.

- 8. Question:** Can you share with us more the work you are doing with recovery support services, including their role in the Substance Abuse Prevention and Treatment block grant and your efforts with the Center for Medicare and Medicaid Services to have these services covered by third party payers? Can you also include a description of the variety of the services offered, and to the extent available, any statistics you may have about what states are offering?

Response: The FY 2016-2017 Uniform Application directs states and jurisdictions to utilize block grant funds for four purposes: (1) to fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time; (2) to fund those priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery; (3) for SABG funds, to fund primary prevention: universal, selective, and indicated prevention activities and services for persons not identified as needing treatment; and (4) to collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment, and recovery support services and to plan the implementation of new services on a nationwide basis. Section III, Behavioral Health Assessment and Plan, Subsection C, Environmental Factors and Plan, includes a request for information regarding states and jurisdictions' activities to promote and services to support recovery.

Not all states are Medicaid expansion states and many have varying structures for integrating and funding recovery support as part of treatment services. SAMHSA's 11 Access to Recovery grantees, regardless of the status of Medicaid in the state, all offer similar types of Recovery Support Services (RSS) to clients to assist them in maintaining abstinence and supporting long term recovery from SUD. Some states are moving towards legitimizing and recognizing Recovery Coaching/Peer Mentoring and becoming certified and eventually leading towards a possible Medicaid reimbursable service.

SAMHSA's Targeted Capacity Expansion - Peer to Peer program is accepting grant applications for fiscal year 2016. The purpose of this program is to expand and enhance service capacity through the provision of peer recovery support services for those individuals with substance use disorders and their family members. It is the expectation that those with lived experience will play an integral role in the design, development, and implementation of this program. A primary program objective is to help achieve and maintain recovery and improve the overall quality of life for those being served. This is assessed through increased abstinence from substance use, employment, housing stability, social connectedness, decreased criminal/juvenile justice involvement, and increased indicators of successful recovery and enrollment in education, vocational training, and/or employment.

Another SAMHSA program, the Recovery Community Services Program-Statewide Network (RCSP-SN) is designed to expand the capacity of addiction recovery community organizations (RCOs) through the development of an organized statewide network. In collaboration with other relevant groups, grantees will work to strengthen the voice of the larger addiction recovery community at the local and state levels. There is a need for greater recognition of the scope and value of addiction recovery community organizations, peer recovery supports and services, and the need for the peer voice to be represented in state-level policy planning and implementation.

The intent of this program is to enhance the presence of RCOs as key partners in treatment, recovery, and affiliated health systems. In accordance with SAMHSA's Strategic Initiative on Recovery Support, this program aims to highlight the value of lived experience through the inclusion of addiction RCOs, which are led by those in recovery, as an organized statewide presence. Although many states have made great strides in recognizing addiction peer recovery services as viable, further efforts are required in order to fully optimize the potential of these services and supports. Through this program, it is expected that the infrastructure of RCOs will be strengthened and the delivery of addiction peer recovery services will be more meaningfully supported.

Additionally, SAMHSA's Bringing Recovery to Scale Technical Assistance Center Strategy, BRSSTACS, serves as a central vehicle for technical assistance, training, and knowledge dissemination related to recovery support services implementation and systems development.

9. Question: Can you share with us more information on collaborative care models and the role they can play to provide access to rural areas?

Response: In 2010, the Health Resources and Services Administration estimated that 89.3 million Americans live in federally-designated Mental Health Professional Shortage Areas with only 156,300 practicing mental health professionals. In rural communities, the disparity of access to mental health services is even greater. Out of the 62 million people living in rural America, 16-20 percent struggle with significant substance abuse, mental illness, and medical-psychiatric conditions." Yet less than 15 percent of physicians practice in rural America and the more specialized the medical discipline, the higher the workforce demand.

Rural areas often lack easy access to health care, early childhood education, nutrition assistance, and other essential human services. Many programs address the needs of adults and children separately and in isolation from other services. As a result, medical clinics are searching for techniques to bridge the gaps that exist between primary healthcare, behavioral health, housing and homeless services, and services for families and children. New practice models that recognize the need for increased integration of various services are being developed. The Institute of Medicine reported that the integration of primary care with mental health influences the overall quality of health care by addressing current disparities for patients with chronic physical illnesses and mental health disorders.

SAMHSA is working with federal partners on several initiatives to improve the integration of services through collaborative care models. Collaborative care is a philosophy that has

many names, models, and definitions that includes the provision of mental health, behavioral health and substance use services in primary care settings. According to the Agency for Healthcare Research and Quality (AHRQ), the key features of Collaborative Care models are: 1) integration of mental health professionals in primary care medical settings, 2) close collaboration between mental health and medical providers, and 3) focus on treating the whole person and whole family.

The SAMHSA/HRSA Primary Behavioral Health Care Integration (PBHCI) program is a good example of a collaborative care model that provides access to integrated service delivery in rural areas. The PBHCI program seeks to improve the physical health status of people with mental illnesses and addictions. Through this initiative, SAMHSA and HRSA provide support to communities to coordinate and integrate primary care services into publicly funded, community-based behavioral health settings, resulting in: improved access to primary care services; improved prevention, early identification, and intervention to reduce the incidence of serious physical illnesses, including chronic disease; increased availability of integrated, holistic care for physical and behavioral disorders; and improved overall health status of clients.

The collaborative care model, as defined by Medicaid, utilizes “an approach to integration in which primary care providers, care managers, and psychiatric consultants work together to provide care and monitor patients’ progress.” The PBHCI grant program requires eligible community mental health centers and/or behavioral health organizations to bring onsite primary care services into their mental health and/or behavioral health settings. PBHCI grantees have utilized a collaborative care model and approach in ensuring that care coordination, care management, monitoring, treatment, and caseload reviews are part of the PBHCI program. PBHCI grantees also focus on the importance of access to services, service utilization, and health outcomes for all populations. Rural grantees utilize telebehavioral health, such as telespsychiatry, and telehealth through their primary care provider to service clients who live in non-urban areas. By implementing a collaborative care approach, the integration team can meet on a re-occurring basis to discuss the needs of the client. Mobile behavioral health and medical vans are important in providing services to rural clients. Utilizing telebehavioral health and telehealth does require adequate technology, for both the service provider and grantee, as well as the client. Some grantees have been able to implement mobile apps to track their treatment and outcomes. This has expanded the access and service use of the PBHCI program.

<http://ruralhealthlink.org/News/TabId/82/ArtMID/664/ArticleID/51/The-Integration-of-Behavioral-Health-and-Primary-Care-Services> cites SAMHSA’s best practice: “Telemedicine –based Collaborative Care”.

Using the Extension for Community Healthcare Outcomes (ECHO) model, SAMHSA is also currently piloting a curriculum and recognition program to build addiction-related competency over time and by integrating technology-assisted training to address identified clinical gaps. SAMHSA is currently utilizing the design of a Project ECHO program, which focuses on care extension and collaborative care, to address opioid treatment issues. Project ECHO’s documented experience in increasing the skills and confidence of primary

care providers in treating patients with infectious diseases and prescribing buprenorphine make this a timely collaboration with significant potential in responding to a major public health crisis.

In SAMHSA's homeless portfolio, the Cooperative Agreements to Benefit Homeless Individuals (CABHI) grant program requires a different type of collaborative care model. The CABHI program calls for the integration of homeless services with behavioral health services through community consortiums. This requirement includes working closely with HUD's Continuums of Care on implementing coordinated entry. Coordinated entry is an important component of an integrated service approach for individuals experiencing homelessness. Most rural communities lack the resources needed to meet all of the needs of people experiencing homelessness. This can result in long waiting times to receive assistance or being screened out of assistance. Coordinated entry systems help communities prioritize service delivery based on the severity of service needs to ensure that people who are the most vulnerable can receive help in a timely manner.

SAMHSA supports Two-Generation approaches that provide opportunities for and meet the needs of children and their parents together. Two-Gen is both within the family as well as coordination of care across systems for the two gen (parent/child or children's) needs and is very promising. Coordinated care models are used though no one model has been adopted. This emerging field is not new, but is now working to learn lessons from what has worked. There is new excitement and momentum from multiple sectors—non-profits, government, and philanthropy—to advance ways to integrate and align programs and systems on behalf of families. Potential systems alignment includes early-education and child care, home-visiting, community action, TANF, workforce development/ job-training programs, higher education, healthcare, schools and more.

The SAMHSA Community Mental Health Services Block Grant mandates that each recipient develop services and supports for individuals experiencing first episode psychosis (FEP). This requirement, first begun in FY 2014, was developed for three specific reasons. First, there is the recognition that individuals with psychotic disorders without appropriate services and supports may experience a lifetime of poor health, early mortality, difficulty in obtaining and maintaining positive personal relationships, unemployment, homelessness, and incarceration. Second, the longer the duration between an individual's first experience with psychosis and appropriate treatment, the poorer the outcomes in general. And third, there are a number of evidence-based practices (EBPs) that can effectively treat, intervene, serve and support individuals with a first episode psychosis, improving their life chances and recovery dramatically.

The EBPs most successfully used in the treatment and support of individuals with FEP are collaborative, interdisciplinary team approaches. These programs leverage an array of specialized providers and the individual's own "natural supports" in the individual's recovery. A challenge in providing and funding these services is that the incidence of psychosis in the general population is small and thus the cost of services, especially through an evidence based interdisciplinary team, is relatively expensive. Another

challenge is that given the low prevalence rate, individuals who have FEP in rural or frontier areas generally do not have easy access to services.

These challenges have led many States to use or consider the use of tele-medicine. The latter is especially powerful in rural areas as it compensates for geographic distance and it can make more efficient use of scarce medical resources such as psychiatry. In the absence of telemedicine complicated by a dearth of providers, individuals in rural areas may not receive timely, needed services until the disease of psychosis has had a significant and devastating impact on their life and chances for recovery. Collaborative approaches to care coupled with telemedicine in rural areas can greatly forestall these negative outcomes.

SAMHSA's National Frontier and Rural Addiction Technology Transfer Center (ATTC) promotes awareness and implementation of tele-health technologies to deliver addiction treatment and recovery services in frontier/rural areas; prepares addiction treatment providers and pre-service counseling students on using tele-health technologies to provide evidence-based addiction treatment services; promote the use of tele-health services by creating national tele-health competencies and policy recommendations, including national license portability; and implements tele-health services through use of state-of-the-art culturally-relevant training and technical assistance activities for the frontier/rural addiction treatment and recovery workforce.

10. Question: Do you plan to evaluate marijuana use and the impact of changing state policies on marijuana as part of the National Survey on Drug Use and Health?

Response: Several authors have attempted to correlate marijuana use rates with changing legislation. The results are mixed. Expert articles in the literature point out that, state level factors that are not yet fully understood contribute to observed differences and that there are not sufficient data from all states, especially Colorado and Washington, to produce a definitive answer. Marijuana laws are heterogeneous, evolving and occur in the context of state factors both before and after legislation, including demographics differences, secular trends and use patterns in subgroups. Given these issues we have no immediate plans to correlate use patterns with legislation.

NSDUH does enable a look at use of marijuana for medical purposes in the United States. Understanding the frequency and correlates of use of marijuana for medical purposes is important for responding from a prevention and intervention standpoint. CBHSQ anticipates future research in this area.

11. Question: Please describe your efforts to ensure that 20 percent of the funds from the Substance Abuse Prevention and Treatment Block grant support bona fide prevention programs. How do you help states evaluate methods for selecting prevention-based programs?

Response: The Center for Substance Abuse Prevention uses multiple strategies to ensure that the 20 percent set aside is used appropriately for bona fide prevention programs. Every two years, each block grant recipient submits a Behavioral Health Assessment and Plan that details each state's planned expenditures over the course of two years for the primary prevention set aside funds for each of the required six substance misuse prevention strategies

(information dissemination, education, problem identification and referral to a substance use/misuse strategy/program, alternatives, community based process, and environmental strategies). In this plan the state is also asked to describe the data, systems, and processes that are used to drive program priorities and evidence based strategy selection. Project officers review these plans and provide technical assistance if requested or required to ensure that states have a reliable method for data driven programming.

On the year where no plan is required, states are required to submit planned expenditures, but not a narrative plan.

The state has two years to spend their award funding. Twelve months after the end of the award period, the state reports on the actual expenditures, the providers funded, and the outcome data collected during the award period. Project officers review and approve this information, or ask for revisions and corrections. Continual project monitoring is also done throughout the year to assist states, as needed, with managing their prevention activities.

Project officers also conduct site visits to grantees to review the Behavioral Health Assessment, Plan, and Report with states, discuss the states' prevention system, their planned and actual expenditures, and discuss if those plans are meeting the state's substance misuse prevention needs and goals. The project officer will assess a states' need for technical assistance and a technical assistance plan will be developed.

- 12. Question:** The fiscal year 2016 House Report requested SAMHSA to make competitive funding opportunities for the Mental Health First Aid Program available to all qualified community mental health education programs. Can you provide an update on the plans for this program in the fiscal year 2017 grant cycle?

Response: In FY 2015, SAMHSA awarded Project AWARE (Advancing Wellness and Resilience in Education) – Community (AWARE-C) grants to a wide range of 69 qualified community mental health educational programs, including municipalities, community behavioral health organizations, community coalitions, faith-based organizations and others. In FY 2016, continuation awards were made to these grantees.

As part of the Project AWARE program, Congress has appropriated an additional \$10 million in FY 2016 for a new Funding Opportunities Announcement (FOA) to support communities affected by civil unrest. The civil unrest program called ReCAST is a five-year grant, funded at up to \$1 million per year that will focus on high risk youth and families living in historically disenfranchised communities with limited resources and high rates of trauma and violence. It is important to note Mental Health First Aid training is an allowable expense in the ReCAST program. It is expected that this program will result in improved services coordination and cultural competence, such as trauma-informed behavioral health and school-based services, evidence-based youth violence prevention programs, and community change, such as community youth engagement policies and practices and strategies that allow local community entities to work together in ways that lead to improved behavioral health, empowered community residents, and reductions in trauma. SAMHSA has been coordinating extensively with the Department of Education to

develop this program and for planned implementation. Also, the Department of Education has received an additional \$5 million in one-time funds to support communities impacted by civil unrest.

In FY 2017, SAMHSA intends to support the continuation of the Mental Health First Aid program within these grants, and offer a new competition for a new cohort of Project AWARE – State Education Agency cooperative agreements. These cooperative agreements provide funding to State Education Agencies and State Behavioral Health Authorities to work collaboratively to help teachers and other adults who interact with youth recognize signs and symptoms of mental illness, improve referrals, and increase access to mental health services for children and youth.

Substance Abuse and Mental Health Services Administration

Budget Hearing: SAMHSA Acting Administrator Kana Enomoto

Questions from Rep. Harris

Wednesday, March 2, 2016

1. **Question:** You discussed responses to the opioid public health crises and specifically cited many elements associated with Naloxone, including the distribution and education to first responders, developing a toolkit, and other overdose death prevention strategies. How are you collaborating with other government agencies such as the Department of Justice that currently have several of these strategies in place? Are these efforts aimed at refining existing programs and strategies or toward creating and implementing new strategies?

Response: As part of the Grants to Prevent Prescription Drug Overdose-related Deaths application, grantees are required to develop an advisory council which will include a core group of agencies that currently engage in efforts to prevent prescription drug/opioid overdose-related deaths, distribute naloxone, and representatives of agencies and organizations responsible for substance misuse treatment and recovery support services. Additionally, representatives from other state, community, and non-profit organizations that work in the areas of public health, criminal justice, corrections, and mental health are also encouraged to be a part of the PDO Advisory Council.

The PDO Advisory Council will provide guidance to the PDO project throughout the five years of the grant. Specifically, PDO grantees are required to collaborate and coordinate funding streams with Health Resources and Services Administration (HRSA) Rural Opioid Overdose Reversal (ROOR) grants in their state. Coordination and collaboration efforts are geared toward limiting the duplication of funds, refining existing programs and strategies and developing and implementing new strategies as necessary.

In addition, SAMHSA participates in the Behavioral Health Coordinating Council (BHCC) Prescription Drug Abuse Subcommittee, which includes HHS, FDA, CDC, NIDA, HRSA, ONC, AHRQ, OSG, IHS, ACL, and CMS. A workgroup is dedicated to naloxone projects, where HHS agencies are kept up-to-date on the progress of such programs. SAMHSA is also a member of the ONDCP Prescription Drug Abuse Interagency Workgroup, which includes DEA, BJA, VA, DoD, and BoP in addition to the federal agencies represented in the BHCC Prescription Drug Abuse Subcommittee. These workgroups and subcommittees provide opportunities to initiate discussion on programs that can complement each other as well as on possibilities for collaboration.

2. **Question:** SAMHSA has said that psychiatrists are eligible to participate in the National Minority Health Scholarship program. Due to a SAMHSA interpretation of a rule, child and adolescent psychiatrists are ineligible for this program because they are deemed pediatric subspecialists. Given that these child and adolescent psychiatrists first train and are later board certified in general psychiatry, and given there is a well-documented and extensive shortage of these psychiatric subspecialists, can you please explain why SAMHSA has denied child and adolescent psychiatrists eligibility for participation in the Minority Health Scholarship program?

Response: SAMHSA's understanding is that this question is referencing SAMHSA's Minority Fellowship Program which for the part of the program that supports psychiatry is currently administered by the American Psychiatric Association. SAMHSA is unaware of any restriction as stated above and APA confirmed there is no eligibility restriction and categorically stated that they do not exclude child/adolescent sub-specialties.

The Minority Fellowship Program (MFP) is designed to 1) provide fellowship recipients with enriching training experiences through participation in the APA September and Annual Meetings, 2) provide recipients with resources to support activities that enhance culturally relevant aspects of their training program, 3) stimulate their interest in pursuing training in areas of psychiatry where minority groups are underrepresented, such as research, child psychiatry, and addiction psychiatry, and (4) develop leadership to improve the quality of mental health care for the following federally recognized ethnic minority groups: American Indians, Native Alaskans, Asian Americans, Native Hawaiians, Native Pacific Islanders, African Americans and Hispanics/Latinos.

3. **Question:** You spoke about utilizing evidence-based practices and working with government partners like NIH. Could you elaborate on how SAMHSA provides feedback to these government partners after your implementation attempts to utilize the research?

Response: The National Registry for Evidence-based Programs and Practices (NREPP) has been in existence since 2007. NREPP is designed to be a decision support system for practitioners and communities, and does not endorse programs or interventions, focusing instead on providing summaries of science-based evaluations that use accepted and transparent methods.

As of April 2016, NREPP has posted reviews of over 390 programs and interventions related to a considerable range of behavioral health services, from very specific clinical interventions to broad-based community prevention initiatives. Starting in 2014, NREPP has increased the rigor and transparency of its review process, and is now identifying and reviewing programs that will help address significant gaps in the evidence-base, while still being responsive to longstanding SAMHSA stakeholders. Through the enhanced Learning Center,

NREPP is providing more online resources and tools to help communities and local level practitioners use evidence-based programming more effectively to improve the quality of behavioral health services.

NREPP provides a systematic approach to identify evidence-based behavioral health intervention practices in the field; however, to date, it has not been used to identify, promote, and provide feedback on evidence-based practices specifically developed by NIH. We will look further into the possibility of developing a more systematic approach of working with our NIH partners to provide feedback.

Department of Labor, Health and Human Services and Education and Related Agencies

Budget Hearing: SAMHSA Acting Administrator Enomoto

Questions from Rep. Roybal-Allard

Wednesday, March 2, 2016

STOP Act Grants

Evaluations of the STOP Act community grants have twice shown their successes in lowering underage drinking rates in participating communities. In FY15 and FY16 SAMHSA awarded 97 grant continuations of these multi-year grants, but we have heard that there were a very large number of new grant applications during those years.

1. **Question:** Can you tell me how many grant applications there were in the last two fiscal years that you were not able to fund?

Response: The last fiscal year in which SAMHSA issued a new grant announcement for STOP Act was 2013. SAMHSA received 247 applications and was able to fund 17; therefore, 230 applications were not funded. SAMHSA currently has a new announcement for this program out and anticipates being able to award 80 new grants.

2. **Question:** How many STOP Act grants there will be in total for FY 17 with both new and continuation grants?

Response: There are 97 STOP Act grants: 17 new and 80 continuations.

3. **Question:** How much of the \$ 5 million for the enhancement grant program will go to grants?

Response: The amount apportioned for FY 2016 for STOP Act is \$7M; \$4.65M will be awarded for new and continuing grants. The balance of funds supports two additional activities, the National Adult-Oriented Media Public Service Campaign and the Interagency Coordinating Committee on the Prevention of Underage Drinking for approximately \$1M each. Level funding of \$7M is anticipated for FY'17 therefore the amount awarded for new and continuing grants should be the same as FY 2016.

4. **Question:** Will you also be proposing new grants in FY18 to help meet this backlog of communities seeking STOP Grants?

Response: New grant competitions are slated for fiscal years 2016 and 2017.

Questions for the Record for Administrator Enomoto from Rep. Roybal-Allard**Excellence Act Implementation**

In the 2014 Medicare SGR bill, Congress included a new bipartisan initiative – called the Excellence in Mental Health Act – that would authorize new Medicaid financing for very intensive community-based mental health and addiction services.

My understanding is that this new program provides up to 24 states with planning grants to develop certification processes and payment methodologies that could be used to expand their behavioral health system, set up 24-hour crisis hotlines and alleviate the pressure on our nation's jails and ERs – and that from this group of applicants 8 demonstration grants will be awarded.

1. **Question:** How is the implementation of this program progressing and when do you expect to award the grants?

Response: The implementation of Demonstration 223 (The Excellence in Mental Health Act) is progressing well and on schedule. Planning grants were awarded to 24 states in October 2015. These 24 states have one year to plan. Planning includes certifying clinics using the SAMHSA criteria, developing a Prospective Payment System based on the CMS guidance, and preparing for data collection to be part of the evaluation. States are required to submit an application in October 2016 to be part of the demonstration. It is important to note that the states that will participate in the demonstration are selected from the 24 planning grantees and the demonstration phase participation is not a separate grant. Eight states will be selected to participate in the demonstration by December 31, 2016.

Currently, technical assistance is being provided to the 24 planning grant states by a federal partner's team. This team includes CMS, SAMHSA, and ASPE. Technical assistance is provided through webinars, individual consultations with states and by disseminating the responses to numerous questions to all states.

The overall goal of the demonstration is to improve the behavioral health of our citizens by expanding community based mental health and substance abuse treatment across the lifespan that integrates behavioral health with physical health care, increases the use of evidence based practices on a more consistent basis and improves access and availability of high quality care. The statute ensures that those services are paid for Medicaid beneficiaries through the Prospective Payment System.

2. **Question:** How does state interest in the Excellence Act compare to other high profile initiatives?

Response: There appears to be significant interest by states as the majority of the states applied for a planning grant and there has been a high level of stakeholder interest comparable to other high level programs at SAMHSA. From the pool of applicants, 24 states were awarded planning grants. Although there is a significant amount of work to be done during the planning grant year, SAMHSA staff are finding that most all of the states are highly engaged in the project and are working diligently to accomplish all the requirements of the grant. High engagement is evidenced by the number of detailed and complex questions that the states are asking, as well as their investment and participation in the individual calls and webinars.

3. **Question:** What will happen to the other 16 states that are not awarded the demonstration grants but have successfully submitted certification processes and payment methodologies?

Response: As part of the Administration's \$500M two-year investment in mental health, CMS is proposing an investment of \$110M to expand the demonstration program by six states. This would yield a total of 14 states included in the demonstration. For states not included, there are indications that states will build on the planning to develop the prospective payment billing system and the certification process to make improvement in the quality and oversight of their behavioral health systems.

Questions for the Record for Administrator Enomoto from Rep. Roybal-Allard**Mental Health First Aid Implementation**

The Mental Health First Aid initiative was a response to a series of tragic school shootings, and through this important initiative, 500,000 Americans have already received training on how to recognize the signs and symptoms of mental health and substance use problems. The training involves improving understanding and providing an action plan that teaches people to safely and responsibly identify and address a potential mental illness or substance use disorder. Mostly importantly, they are also equipped with a plan of action to refer individuals in psychiatric crisis to mental health treatment.

It is my understanding that SAMHSA initially formed a partnership with the U.S. Department of Education to emphasize the training of principals, teachers, coaches and other school personnel. However, the FY 2016 Labor/HHS appropriations bill included committee report language urging SAMHSA to shift Mental Health First Aid's focus to local law enforcement agencies, fire departments, emergency medical units and hospital systems.

1. **Question:** Will you please update the Committee on SAMHSA's transition plan to add first responder audiences?

Response: As First Responders, such as law enforcement officials and emergency response personnel, are often in a position to interact with a youth who may be experiencing a psychiatric crisis, they play a critical role in improving early identification and referral. In FY 2016, with the same funding level available as in FY 2015, funds were used for continuation awards to existing grantees, and therefore not available for a new competition that would focus on increasing MHFA training for first responders. However, a number of our existing grantees in the Project AWARE-SEA program and the AWARE-C program have identified first responders as a critical audience in their efforts to increase mental health literacy. Grantees have included juvenile justice, law enforcement, and others as key partners and have provided trainings for first responder groups.

In addition, as part of the Project AWARE program, Congress has appropriated an additional \$10 million in FY 2016 for a new Funding Opportunity Announcement (FOA) to support communities affected by civil unrest. The civil unrest program called ReCAST is a five-year grant, funded at up to \$1 million per year per grantee that will focus on high risk youth and families living in areas that have experienced civil unrest which typically have limited resources and high rates of trauma and violence. Grantees under this program will coordinate and work in partnership with community services systems including first responders. Law enforcement engagement is one of the primary approaches of the program. It is expected that this program will result in improved services coordination and cultural competence, such as trauma-informed behavioral health and school-based services, evidence-based youth violence prevention programs, and community change, such as community youth engagement policies and practices and strategies that allow local community entities to work together in ways that lead to

improved behavioral health, empowered community residents, and reductions in trauma. The Department of Education has also received an additional \$5 million in one-time funds to support communities impacted by civil unrest.

Questions for the Record for Administrator Enomoto from Rep. Roybal-Allard

Opioid Addiction and Treatment

This country is battling an epidemic of opioid addiction and overdose that is national in scope, massive in scale and continuing to worsen. It is my understanding that the vast majority of opioid addicted individuals relapse to illicit opioid use within a few months of completing or dropping out of opioid maintenance therapy. However, in the treatment of opioid addiction, non-opioid alternatives appear to be underutilized. In 2015 over 1.5 million individuals were prescribed opioid replacement drugs (specifically, methadone or buprenorphine) for opioid addiction, while fewer than 100,000 received non-opioid, abstinence-based relapse prevention medication.

1. **Question:** What is SAMHSA doing to advance the use of abstinence-based relapse prevention medications and counseling for individuals completing or dropping out of opioid maintenance therapy?

Response:

SAMHSA has recently published a funding announcement for its Medication-Assisted Treatment: Prescription Drug and Opioid Addiction grant program. In this announcement, SAMHSA has required that grantees prioritize treatment regimens that are not susceptible to diversion and has included as an allowable activity the provision of treatment services whose goal is specifically abstinence from all prescription opioids and heroin.

Additionally, SAMHSA has also provided training on this topic. There are two specific trainings that deal with this issue through SAMHSA's Provider Clinical Support System (PCSS) cooperative agreement. The first, "Assessment and Treatment Planning," is an intensive training. At the completion of the workshop, participants are able to identify the key elements of a comprehensive assessment process and the components of a patient-centered treatment plan, write an interpretive/integrated summary, and conduct comprehensive assessments, and develop patient-centered treatment plans in their organizations. The training covers the variety of MAT regimens offered.

The second, "Opioid Treatment Program Clinical Staff Education," is conducted annually in eight different locations throughout the country. This one day training prepares participants to understand and use initial treatment screening, admission procedures, and

assessment techniques; methadone pharmacology, and clinical pharmacotherapy; buprenorphine and naltrexone pharmacology as clinical pharmacotherapy; drug testing as a tool, etc.

In addition, every eighteen months SAMHSA is one of the co-sponsors of the AATOD conference for opioid treatment programs (OTPs). Abstinence-based relapse prevention medications and counseling is traditionally the focus of at least one or two workshops at the conference. Lastly, the OTPs can request training in abstinence-based relapse prevention medications and counseling through SAMHSA's PCSS grant program on demand.

2. How many physicians has SAMHSA's Provider Clinical Support System trained in the use of non-opioid abstinence-based relapse prevention medications and counseling in order to prevent relapse following detoxification?

Response:

The Provider Clinical Support System conducts trainings on detoxification before the individual goes on Naltrexone. PCSS have trained 2,159 physicians in this area.

3. The report to the FY 2016 Consolidated Appropriations Act directs SAMHSA to "update all of its public-facing information and treatment locators such that all evidence-based innovations in counseling, recovery support, and abstinence-based relapse prevention medication-assisted treatments are fully incorporated. How is that update proceeding?

Response:

SAMHSA has developed an aggressive action plan to take steps to ensure its treatment locator is updated especially with respect to the opioids focus raised in the most recent report language. One of the first steps in that process is the improvement of contact information for the locator. SAMHSA plans to survey for all Drug Addiction Treatment Act of 2000 (DATA 2000) waivered physicians to update contact information and identify physicians who no longer provide MAT services. Additions to the list are initiated upon a physician's receipt of DATA 2000 waiver certification. At that time, the physician provides his/her information and may opt in to include their contact information on the treatment locator list.

SAMHSA plans to institute a way to more regularly update physician contact information. The intent is to have the new process in place before finalization of a Notice of Proposed Rulemaking to amend 42 C.F.R. part 8 rule. The physician information will be updated at least annually.

The 2015 National Survey of Substance Abuse Treatment Services (N-SSATS) and 2015 National Mental Health Services Survey (N-MHSS) recently finished data collection.

These two surveys collected information on treatment types offered by substance use and mental disorder treatment facilities. In less than a month, the following treatment types will be available for public searches in SAMHSA's Behavioral Health Treatment Services Locator:

Individual psychotherapy
Couples/family therapy
Group therapy
Cognitive/behavioral therapy
Dialectical behavior therapy
Behavior modification
Integrated dual disorders treatment
Trauma therapy
Activity therapy
Electroconvulsive therapy
Psychotropic medication
Telemedicine therapy
Substance abuse counseling
Trauma-related counseling
Rational emotive behavioral therapy
Alcohol Detoxification
Benzodiazepines Detoxification
Cocaine Detoxification
Methamphetamines Detoxification
Opioids Detoxification
Treatment for gambling disorder

Treatment for internet use disorder
Individual counseling
Group counseling
Family counseling
Marital/couples counseling
12-step facilitation approach
Brief intervention approach
Contingency management/motivational incentive
Motivational interviewing
Anger management
Matrix Model
Relapse prevention
Methadone maintenance
Methadone maintenance for predetermined time
Methadone detoxification
Buprenorphine maintenance
Buprenorphine detoxification
Relapse prevention with naltrexone
Naltrexone (oral)
Vivitrol® (injectable Naltrexone)
SAMHSA-certified Opioid Treatment Program

Questions for the Record for Administrator Enomoto from Rep. Roybal-Allard**Substance Abuse Prevention**

The FY17 budget justification proposes \$12 million for the CSAP Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths program.

1. **Question:** How will the naloxone grants in CSAP be used for actual prevention of substance use?

Response: Grants to Prevent Prescription Drug Overdose-related Deaths grantees will be required to develop training and dissemination plans as part of the program's implementation. Grantees will utilize SAMHSA's Opioid Overdose Prevention Toolkit to develop education strategies. The toolkit contains five guidance sections to assist in this process; 1) Facts for Community Members, 2) Five Essential Steps for First Responders, 3) Information for Prescribers, 4) Safety Advice for Patients & Family Members, and 5) Recovering From Opioid Overdose. Utilizing this tool kit will allow for consistent program development and implementation and provides guidance on how grantees can develop a comprehensive prevention strategy that includes both naloxone distribution and substance misuse prevention education.

2. Why are these grants considered prevention and included under CSAP?

Response: These grants have a heavy focus on substance use prevention and dissemination of prevention education. Prevention education of individuals, families, communities, and states is a key component of the program. Grantees will train first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implement secondary prevention strategies, including the purchase and distribution of naloxone to first responders.

Questions for the Record for Administrator Enomoto from Rep. Roybal-Allard**Youth Violence Prevention**

It has been repeatedly documented that heavy drinking increases the likelihood of violent behavior and that teenagers who drink heavily are more likely to cut class or skip school, perform poorly in school, take sexual risks, and commit suicide. Young people are at especially high risk for two of the most serious problems associated with drinking during adolescence: violence and suicide. Unfortunately, with the elimination of the Youth Violence Prevention Program, we have lost a valuable resource in the fight against youth violence.

1. Question: Other than the STOP Act, has SAMHSA invested in any programs that will seek to prevent or reduce underage drinking, thereby contributing to a potential decrease in violence amongst teens?

Response: Yes, SAMHSA has invested in other program efforts to reduce underage drinking. Each of the referenced programs below address risk and protective factors related to underage drinking and their respective efforts recognize violence as an associated consequence of underage alcohol use.

SAMHSA's Center for the Application of Prevention Technologies (CAPT) provides training and technical assistance services and practice resources on the prevention of underage drinking for our prevention grantees included under the Substance Abuse Block Grant program and grantees included under Programs of Regional and National Significance.

SAMHSA's Underage Drinking Prevention Education Initiatives focuses on the development and delivery of a wide variety of resources and activities (e.g., public education, community planning tools, information briefs, community engagement activities) targeted to the prevention of underage drinking. This contract also supports the development and maintenance of the Interagency Coordinating Committee on the Prevention of Underage Drinking (ICCPUD) portal website, <https://www.stopalcoholabuse.gov>.

2. Question: Please tell the committee about these efforts, and whether you consider the "Talk, They Hear You" Campaign to be successful in this regard.

Response: SAMHSA considers the "Talk They Hear You" campaign to be successful. Studies have shown that parents have a significant influence on young people's decisions about alcohol consumption, especially when parents create supportive and nurturing environments in which their children can make their own decisions. If parents talk to

their kids directly and honestly, they are more likely to respect family rules and advice about alcohol use. When parents know about underage alcohol use, they can protect their children from many of the high risk behaviors associated with it.

The campaign's focus on helping parents to engage in conversations about alcohol use with their children early on is a protective strategy to prevent underage alcohol use and its related consequences.

A conservative estimate of the overall reach of the campaign to date is 5.3 billion media impressions, or the number of times people have seen the campaign ads or messages.

These figures are supplemented in part by a recent placement in national retailers. "Talk. They Hear You" has the support of more than 40 national groups, including CADCA and the National Parent Teacher Association, which are assisting SAMHSA in disseminating the campaign. This campaign provides effective public education messages and tools for parents to practice positive parenting around underage alcohol use.

TUESDAY, MARCH 15, 2016.

BUDGET HEARING—DEPARTMENT OF LABOR

WITNESS

HON. THOMAS E. PEREZ, SECRETARY, DEPARTMENT OF LABOR

OPENING STATEMENT FROM REPRESENTATIVE COLE

Mr. COLE. We will go ahead and call the session to open.

Good morning, Mr. Secretary, and welcome. It is good to have you here, as always. I want to thank you for your service. And the committee recognizes the demanding role you have, and I appreciate your work on behalf of the American people.

This hearing is to review the Department of Labor's fiscal year 2017 budget request. The department's request for \$12,800,000,000 in discretionary appropriations is a 5 percent increase over the fiscal year 2016 enacted level.

That is a substantial increase when compared to the increase authorized under the bipartisan budget deal for fiscal year 2017 agreed to last fall and signed by the President. As you know, that is essentially a flat funding top line for us. Although as I told you in the back, you know, we occasionally rob Peter's to pay Paul. And if you are lucky, you may be a Paul in all this.

Increases are requested across the department, which makes the committee's task of prioritizing the programs that need additional funding from those that would be nice to have to even more difficult. In the budget, there are areas of agreement. The committee is pleased to see the Governor's Reserve proposed at the authorized level of 15 percent after several years of reduced allocations.

I am also personally interested in the appropriately scaled Native American youth pilot proposal. I hope the department will continue to work with this committee to find ways to more effectively serve this population.

The committee also appreciates the department's focus on serving the job training and employment needs of the Nation's veterans and particularly the department's requested increase for the Homeless Veterans' Reintegration Program. No veteran should have to live on the streets after serving our country, and we hope the department will continue to work with the committee and with Congress to eliminate veterans homelessness.

Last, but certainly not least, the committee strongly supports the OSHA Voluntary Protection Program. We look forward to receiving the report requested in last year's House committee report and hope that the department will continue to work with us and with the Education and Workforce Committee to secure the resources necessary to expand the reach of and the participation in this program.

MANDATORY BUDGET INCREASES

Though there are numerous areas where we believe we can work with the department, the committee continues to have serious concerns with many of the proposals in this budget. The budget proposes \$17,600,000,000 in new mandatory spending. These proposals exceed the entire discretionary budget for the department by over \$5,000,000,000.

Furthermore, Congress is unable to effectively assess these proposals because there is no proposed legislative language. Frankly, we wonder why these proposals are even before this committee, which does not have jurisdiction over mandatory funding. If they are anything more than a budgetary gimmick, they should go before the appropriate committees of jurisdiction.

DEPARTMENTAL ENFORCEMENT PROGRAMS

The committee also continues to have concerns with the department's overreliance on punitive labor enforcement. The budget requests a substantial increase for Wage and Hour Division, OSHA, MSHA, and other enforcement programs despite clear direction from the committee to adopt a more balanced approach that places more emphasis on cooperative compliance and assistance efforts.

The committee recognizes that enforcement is an important part of worker safety programs. We continue to believe that worker safety should be the goal of these programs, not generating revenue from excessive penalties and fines. Many employers who want to do the right thing and protect their employees' safety are frustrated with the unforgiving and punitive approach the department has taken toward enforcement programs, especially the budget increases proposed to support politically motivated and controversial regulatory proposals.

DEPARTMENTAL REGULATORY PROPOSALS

The committee also remains deeply concerned by the recent trend of making major changes in policies through administrative interpretation. Those efforts circumvent the intent of Congress in the Administrative Procedures Act to interpret and implement the law of the land through the formal regulatory process.

Despite clear bipartisan direction from Congress to implement such policy changes through the proper regulatory process, the department continues to issue controversial administrative interpretations to impose policies in an expeditious and disingenuous manner that circumvent the role of Congress in policy development and deprives employers and the public of their legal right to information and opportunity to comment on the record.

In addition, the department continues to pursue controversial and partisan regulatory proposals on the definition of fiduciary, overtime, crystalline silica, injury and illness reporting, and reporting requirements for legal advice regarding unionization and continues to dismiss the concerns of many Members of Congress in both parties, as well as affected employers. We hope that the department will engage with the committee and the Congress to address these policy issues on a bipartisan basis.

I know Members have many questions to ask, and this is a full morning of hearings in a compressed time schedule. So you will see Members, as I know you are aware, coming in and out, but we will certainly try to get as many of these questions in as we can.

I want to yield now to Chairman Rogers for any opening statement that he would care to make.

OPENING STATEMENT FROM REPRESENTATIVE ROGERS

Chairman ROGERS. Mr. Chairman, thank you very much for yielding me this time.

As you say, we have got a lot of hearings going on. I have got to go to three different ones this morning. So I am going to say something and then have to leave to go to two more hearings.

At the outset, Mr. Secretary, I want to thank you for your interest and your travel to my congressional district in recent months. As you are aware, over the last 7 years, eastern Kentucky has been hit hard with the loss of over 10,000 coal mining jobs and related jobs and, more recently, the temporary shuttering of the AK Steel plant in Ashland due to steel dumping by other countries.

SOAR INITIATIVE

As a result, we have worked at the local level to establish a bipartisan regional community development initiative, known as Shaping Our Appalachian Region, SOAR, designed to help diversify and grow the economy almost from anew. So thank you, Mr. Secretary, for speaking at the SOAR summit last year. Around 2,000 leaders from around the region listened to you as you highlighted the importance of education and job training.

As you saw during your visit, SOAR is partnering with workforce development groups like the Eastern Kentucky Concentrated Employment Program to help create jobs and opportunities in what I like to call "Silicon Holler." Important pieces of this initiative include innovation, workforce development, job creation. And I appreciate your continued support of those programs in the budget, as well as your continued interest in SOAR in Kentucky.

DOL FY 2017 BUDGET REQUEST

Turning to your budget request as a whole, regretfully, I must repeat a message I have conveyed at nearly every budget hearing we have had to date. As you know, last year Congress and the President reached an agreement setting discretionary budget caps for fiscal 2016 and 2017, and I am proud that the omnibus bill that we passed in 2016 adhered to the terms of that bipartisan agreement. Congress made the tough choices necessary to live within our means, and we will do it again for fiscal 2017.

That said, I am very disappointed that the President has put forth a budget request in order to avoid the very same budget caps he signed into law last year. For fiscal 2017, Labor requested \$12,790,000,000 in discretionary funding, a 5 percent increase over fiscal 2016 enacted levels. That number proposes increases for nearly every program at the department.

This proposal is unrealistic, given current law under the bipartisan budget agreement. In particular, I am particularly extremely

troubled by the department's proposal to create unauthorized new mandatory grant programs with no proposed legislative language or justification, as pointed out by the chairman.

Your mandatory funding proposals include \$3,000,000,000 for the American Talent Compact, \$5,500,000,000 for the Open Doors for Youth program, and the list goes on. Combined, these mandatory proposals are larger than the entire Department of Labor's discretionary budget. Not only are these proposals functionally unworkable, but this committee, we don't have the jurisdiction over mandatory programs.

DOL REGULATORY AGENDA

Finally, the department's partisan regulatory agenda is also very disturbing. A final Department of Labor rule is anticipated soon relating to the definition of fiduciary.

I, along with Speaker Ryan and a majority of Members of Congress, have repeatedly laid out the horrible impact this regulation will have on small businesses and individuals saving for retirement. Yet this agency has pushed full steam ahead with this regulation that will force financial advisers to stop working with individuals that have small retirement accounts.

Along with the fiduciary rule, you are also working on rules on overtime requirements, minimum wage, and paid leave for Federal contractors. This agency is a prime example of rulemaking gone amok, and I hope that we can have a discussion about how to rein in these activities in the future.

In the meantime, thank you for joining us today, Mr. Secretary. Look forward to hearing your testimony.

And I have to leave shortly to attend two other hearings, but don't let that reflect on my willingness to work with you.

Thank you.

Mr. COLE. Thank you, Mr. Chairman.

If I could now go to my working partner, the good lady from Connecticut, for any remarks she cares to offer.

OPENING STATEMENT FROM REPRESENTATIVE DELAURO

Ms. DELAURO. Thank you very much, Mr. Cole.

And thank you, Secretary Perez, for joining us this morning and for your leadership on behalf of American workers and their families.

The Department of Labor exists to represent the workers who form the backbone of our economy and are the engine of its growth. It helps provide them with stability by protecting their wages, working conditions, health benefits, and retirement security.

The department also supports a nationwide workforce development system, which partners with private employers to train a skilled workforce for the high-growth, high-demand industries of the future. And our economy has seen significant gains in the past year. We have added 225,000 jobs per month, the unemployment rate is below 5 percent, and we are seeing improvement in the labor force participation rate.

But too many working families today are still not being paid enough to make ends meet. So these broad economic gains do not manifest in the everyday lives of working people. Hourly earnings

are barely increasing at the rate of inflation. A mere 13 percent of the workforce has paid family leave through their employers. And at least 39 percent of the workforce does not have access to paid sick days.

And that is why the department's mission of fighting for working Americans has never been more important than it is now. Last year, we were able to make important investments in the Labor, HHS bill, including an increase of \$86,000,000 for job training grants under the Workforce Innovation and Opportunity Grant and \$90,000,000 for a new apprenticeship grants program. We were able to secure a much-needed boost of \$17,000,000 for the Bureau of Labor Statistics.

CUTS TO DOL BUDGET IN FY 2016

But I am disappointed that despite these gains, the 2016 enacted level was still \$1,400,000,000 below the 2010 level, a cut of 10 percent. I am also disappointed at the overall increase of less than 2 percent for Labor in 2016, especially because this reflects a failure to provide additional funds for worker protection agencies. OSHA, MSHA, the Wage and Hour Division, and EBSA were flat funded, and the OFCCP was cut by \$1,000,000.

ILAB was cut \$5,000,000. ILAB is one of the main tools that we have to root out and combat the causes of these inhuman labor practices worldwide. And as we consider new trade agreements with major implications for labor at home and abroad, we cannot slash funding to this crucial resource.

I am also disappointed that we were unable to fund a modest request of \$35,000,000 for State Paid Leave. Paid family and medical leave is an idea whose time has come. It is fair, it is humane, and it is popular.

This is a national issue that has been raised by members of both parties. The discourse at the national level is about paid family leave. Families who work hard deserve our support to get through tough periods in their lives. Helping them keep their jobs and hanging onto their paychecks will boost our economy. There really is no reason not to enact paid family and medical leave.

RECEIVING PROPORTIONAL 302(B) ALLOCATIONS

Last year's omnibus moved the Federal budget in the right direction, raising the caps on defense and nondefense discretionary spending and increasing much-needed funding for programs that support our economy and the quality of life of citizens across the country.

Chairman Cole has heard me say this before, but I am troubled that the Labor, HHS bill received only a fraction of its fair share of the \$66,000,000,000 increase provided by last year's budget deal. While the other nondefense subcommittees received an average increase of 6.9 percent last year, the Labor, HHS bill increased by only 3.4 percent.

This subcommittee represents 32 percent of nondefense discretionary spending. Our allocation should be proportional to that figure, and I hope to see that realized this year.

FY 2017 PRESIDENT'S BUDGET

That brings me to the topic of today's hearing, the budget request for the Labor Department. I might add with regard to an increased allocation by this committee, that would mean we would have to put less emphasis on mandatory spending if we had an appropriate allocation for what needs to get done through this committee.

The budget request for the Labor Department. Mr. Secretary, there is a lot of good in the request, and particularly, I applaud \$255,000,000 increase for job training programs, including increases for State grants under the Workforce Innovation and Opportunity Act, Job Corps, and Reintegration of Ex-Offender programs.

I'm also pleased to see an increase of \$12,000,000 to help homeless veterans return to the workforce. I want to note that last year Connecticut became the first State to end chronic homelessness among veterans, a significant achievement, and we can all agree that military veterans deserve to have a job waiting for them when they transition back to civilian life.

I am pleased to see an increase of \$15,000,000 for ILAB. In my view, ILAB should receive a much, much larger increase to carry out the essential work that they do, but this increase is a welcome proposal.

But I am disappointed that there is no request for discretionary funding for State paid leave. I realize this is a heavy lift in this environment, but we need to keep fighting until working families do not have to forego pay or lose a job when serious medical or care giving needs arise.

In order to do what we need to do to support programs that provide job training opportunities and enforce laws that protect low-wage workers, this subcommittee needs additional funds in fiscal year 2017.

FINALIZING REGULATIONS

Finally, let me urge the Department of Labor to finalize the regulations that you have been developing over the last few years, including the silica rule, fiduciary rule, and overtime regulations. Hard-working Americans deserve safe workplaces. They deserve to have their retirement funds protected from self-interested advisers, and they deserve fair pay for their work. This is precisely what the Department of Labor exists to do, to represent and to protect working Americans.

I thank you, and I look forward to our discussion this morning. Thank you, Mr. Chairman.

Mr. COLE. I thank the gentlelady.

And now, Mr. Secretary, we would recognize you for any opening remarks you would care to make to the committee.

OPENING STATEMENT FROM SECRETARY PEREZ

Secretary PEREZ. Thank you, Mr. Chairman.

It is an honor to be here with you and Ranking Member DeLauro and all the members of this committee. I look forward to discussing our 2017 request for discretionary funding that is pending before

this subcommittee. I am very grateful for the constructive dialogue that we have had throughout my tenure, and I have profound respect for your leadership and our ability to collaborate together.

As we prepare for the final 10 months of this administration, I think it is worth reflecting on where we have been, where we are, and where we need to go. President Obama, as you know, inherited an economy in freefall. In the 3 months before he took office, the economy hemorrhaged roughly 2.3 million jobs. Seven years later, we have made tremendous progress, climbing out of the worst economic crisis in generations.

We are now in the middle of the longest streak of private sector job growth on record, 6 straight years to the tune of 14.3 million new jobs. Unemployment is down from 10 percent to now 4.9 percent. Auto sales reached a record high last year.

While we have considerable unfinished business, we have made undeniable progress, and I am proud to say that the Labor Department has played an important role in helping this recovery. Our work is critical to fortifying the basic pillars of the middle class—an education and training that allows you to move up the ladder of success in your job, healthcare that is affordable and accessible, a fair day's pay for a hard day's work, a roof over your head, a mortgage that won't go underwater, and the opportunity to save for a secure and dignified retirement.

PLANS FOR THE FY 2017 BUDGET REQUEST

These pillars took a beating during the great recession, but I have never felt more confident in the resilience of our economy, our workers, and our employers. I believe that our fiscal 2017 budget request will help us continue this important work to sustain this recovery while helping us to address the unfinished business of ensuring shared prosperity for everyone.

For instance, despite a major decline in the number of long-term unemployed, there are still 2.2 million people who have been out of work for 27 weeks or more. To get them the help they need, we want to continue to strengthen the Reemployment Services and Eligibility Program, which has a proven return on investment.

Our budget builds on the increased investments made by Congress last year, adding \$70,900,000, for a total of \$185,000,000. These dollars will expand services to all veterans receiving benefits through the unemployment compensation for ex-service members, as well as one-third of the unemployment insurance claimants most likely to exhaust their benefits and become long-term unemployed.

I am also grateful for Congress' bipartisan support in passing WIOA a couple of years ago and providing the resources to make that promise of the law a new reality and a wonderful reality. Our fiscal 2017 budget builds on this foundation by bringing WIOA formula funding programs to their fully authorized amount while continuing the 15 percent Governor's set-aside for statewide activities that I made great use of when I was a State labor secretary, and which I strongly support.

We are also proposing modest increases specifically to help dislocated coal industry workers and to pilot better ways to serve Native American youth who don't live on reservations, something I know has been a longstanding priority of yours, Mr. Chairman.

Apprenticeship has been one of the cornerstones of our workforce development efforts. As I mentioned this morning, a recent independent study showed that for every Federal dollar invested in apprenticeship, that is a \$27 return on investment. That is real money, and I applaud and appreciate the \$90,000,000 investment that you made in the most recent budget. We are hoping to leverage that to literally upwards of a couple billion dollars in return.

Apprenticeship is making a comeback in this country, and we had a \$175,000,000 grant program that was through H-1B funds that has been wildly successful and is increasing the footprint of apprenticeship.

The department's mission isn't simply to help people find good jobs, but to ensure that there are strong labor standards that give them the best possible quality of life, and that is why our enforcement offices play such a critical role. So, for instance, our Wage and Hour Division has been able to secure back wages totaling nearly \$1,600,000,000 for 1.7 million workers.

PERSUING AN ACTIVE REGULATORY AGENDA TO PROTECT WORKERS

All told in fiscal year 2017, we are requesting \$1,900,000,000 to continue to safeguard the health, safety, wages, working conditions, and retirement security of our workers. We continue to pursue an active regulatory agenda in this space in consultation with all stakeholders, including Members of Congress.

In recent decades, the erosion of overtime standards, for instance, has undermined the economic stability of many white collar workers who I have met—some of whom I have met. They work 60, 70 hours a week while earning as little as \$24,000 a year.

So we have proposed a new rule that will expand overtime pay to millions of people potentially, and the value proposition is simple. People who work extra should be paid extra. This rule, the proposed final rule, was sent to OMB for final review yesterday.

I believe it is a false choice to suggest that we can either have economic growth or workplace safety. We can and must have both, and that is why our Occupational Safety and Health Administration is close to issuing an updated rule that will significantly reduce workers' exposure to silica dust and save many lives each year.

Given an aging population, the department's retirement mandate has never been more important. For the last several years, we have been working on a conflict of interest rule which we expect to finalize soon based on a common sense principle. If you want to give financial advice, you have to put your clients' best interests first. That conflicted advice costs families billions of dollars each year, and this is one of the most important steps we can take to enhance retirement security.

CHALLENGES FOR THE REMAINING TERM

I love my job, Mr. Chairman, and in this job, I make sure that I make house calls. In my house calls, I have seen both the remarkable progress we have made and the unfinished business.

Last year, I met a guy named Bruce Ives, who was a Missouri man who was laid off from his client services job. He lost his home.

He lost his dignity. At age 60, Bruce faced some remarkable challenges getting back to the workforce.

But "Match.com," which is what I often call the Department of Labor, stepped in. He was able to enroll in a State program called Reboot U, which helped him get computer programming skills that led to a job making \$36 an hour as an IT analyst at the University of Kansas Hospital. It was a joy to meet him and to see the hop in his step and the dignity in his voice.

I have seen so many inspiring stories like this, but I have also visited with all too many people whose boat has not been lifted yet by the rising tide and who are still on the outside looking in. Like the fast food worker in Detroit who was sleeping in her car with her three kids because she had been evicted from her apartment. Or the school bus driver I met in Connecticut—when I was with Congresswoman DeLauro—who had to take her newborn baby on her bus route because she doesn't have paid leave.

Or a gentleman named Alan White, whom I met in Buffalo last week on a visit, whose life is in the process, frankly, of being cut short by silicosis. These challenges that they confront keep me up at night, and the opportunity to help them and create shared prosperity and an economy that works for everyone is what gets me out of bed in the morning each day with a hop in my step.

I look forward in these remaining 311 days until the weekend to working every day to make every day count and to working together with you whenever possible, and I appreciate the bipartisan spirit that you have approached everything that you have done, Mr. Chairman, and I look forward to any questions that you and other members of the committee may have.

[The information follows:]

**STATEMENT OF THOMAS E. PEREZ
SECRETARY OF LABOR
BEFORE THE
SUBCOMMITTEE ON LABOR,
HEALTH AND HUMAN SERVICES, EDUCATION AND RELATED AGENCIES
COMMITTEE ON APPROPRIATIONS
UNITED STATES HOUSE OF REPRESENTATIVES**

March 15, 2016

Chairman Cole, Ranking Member DeLauro and members of the Subcommittee, thank you for the invitation to testify today. I appear before you with a great sense of optimism and pride – not just about what has been achieved in these past seven years, but about the direction we are headed in the future. I am especially proud of the Department’s role in helping shape this future – a future of opportunity and shared prosperity, a future of robust job growth and a thriving middle class, a future where workers nationwide get the skills and training they need to receive a fair wage without risking their health or safety.

The 2017 President’s Budget reflects this sense of optimism and provides the resources necessary to address the unfinished business of this recovery. It builds on seven years of investments that have helped us climb out of the worst economic crisis in generations. The Budget supports the President’s vision of an economy that works for everyone – one where your zip code doesn’t determine your destiny; one where a full-time job pays a living wage; one where a lifetime of work leads to a dignified retirement; one where America’s businesses are on a level playing field with their international counterparts; and one where job security also means that the workers are safe from unlawful discrimination, retaliation, and workplace hazards.

We’ve come a long way since the darkest days of the Great Recession. We’ve now experienced 72 months of private sector job growth, with the unemployment rate down to 4.9 percent, the lowest level since February 2008. Yet this recovery is not reaching every community and every household. Too many people are finding opportunity beyond their reach. Too many people, no matter how hard they work, can’t get by, let alone get ahead. Some people have given up hope, leaving the job market completely. Others have settled for part-time employment when they want and need a full-time job. Many youth – especially those who grew up in poverty – do not see hope for the future. We have accomplished a lot together, but there is still more work ahead. The Department’s FY 2017 Budget will allow us to do that work, supporting bipartisan investments made to date and proposing new investments that meet important needs.

Training Americans for Jobs of the Future

In my two and a half years as Secretary of Labor, we have made significant progress in building a training system that invests in the workforce of today and tomorrow. The Department worked in 2014 with the Vice President and other agencies to conduct a thorough review of America’s training programs, to make them more job-driven and more responsive to employers’ needs. I’m grateful for the bipartisan leadership in Congress that led to passage of the Workforce Innovation and Opportunity Act (WIOA), which we are hard at work implementing. We have lifted up apprenticeship as never before, making the largest-ever federal investment in this learn-while-

you-earn model and appreciate Congress appropriating resources that will allow us to continue expanding apprenticeships. We know more now than ever about what works in job training – we need to foster partnerships between the workforce system, employers, workers, intermediaries and others so that we are preparing workers for in-demand jobs. We need to be data driven and meet the diverse needs of our workforce. The Department of Labor, with our partners throughout the Administration and the states, is leading the process of making these important strategic changes.

Our employment and training programs served over fifteen million people in the Program Year ending June 30, 2015. The reforms supported by WIOA – like accountability for business engagement and new requirements to measure and report additional program outcomes – are tools that help us identify what is working, fix or end programs that aren't effective, and provide good information to workers so they can select training programs that are effective. The Department's staff has been working tirelessly, and in strong partnership with colleagues at Education, HHS, and elsewhere, to support and implement WIOA's alignment of employment and training programs, so we can provide more effective services with maximum impact. In FY 2016, Congress appropriated additional resources for a number of WIOA programs. The FY 2017 Budget builds on this foundation by bringing the WIOA formula programs to their fully authorized amount while continuing the 15 percent Governor's set aside for statewide activities. The Budget also includes resources for additional staff to help all states and localities implement WIOA, as well as technical assistance to states to improve the quality of services provided to participants. An investment of \$40 million will help states track longitudinal educational and employment outcomes of WIOA participants, so we can know what services are most effective. In FY 2017, we are also proposing modest increases specifically to assist dislocated coal industry workers and to pilot ways to better serve Native American youth who do not live on reservations.

Apprenticeship is one model where we have evidence of substantial success. Apprenticeships offer a path to the middle class, as well as the opportunity for trainees to earn while they learn. Much of apprenticeship's success is attributable to the strong connection between the trainee and the employer and, in many cases, the strong partnership between management and labor. Those who finish their program secure an average starting salary of \$50,000, and over the course of their careers they earn \$300,000 more than their peers who did not participate in an apprenticeship program. Since the President launched the American Apprenticeship Initiative in 2014, we have 75,000 more apprentices in training, a step towards the President's goal of doubling the number of apprentices. Over 165 employers and other organizations have joined the Department's LEADERs program to be champions of the apprenticeship model. The Department's Registered Apprenticeship College Consortium, now 239 colleges and 976 training programs strong, make it easier for apprentices to earn college credit. I am appreciative of Congress appropriating \$90 million in FY 2016 for apprenticeship grants, and the FY 2017 Budget continues this investment. The Budget also proposes \$2 billion in mandatory funds for an Apprenticeship Training Fund that will provide grants to states and regions to bring more employers to the table in providing high-quality apprenticeships.

Apprenticeship, like most successful workforce programs, depends on partnerships. To scale successful partnerships, we are requesting \$3.0 billion in mandatory funding to create an American Talent Compact. This mandatory competitive funding would create regional

partnerships between workforce boards, economic development organizations, employers, and educational institutions to train workers for in-demand jobs. It would give employers better forums to communicate their skill needs and help educators better understand the job market, so they can tailor their courses, certificates, and degrees accordingly. We anticipate being able to train and place 90,000 people per year through this program.

The Job Corps program has trained nearly 2.7 million people since its inception more than half a century ago. The program was created to open doors of opportunity for at-risk young people from diverse backgrounds, giving them the tools to change course and reach higher rungs on the ladder of opportunity. We now have Job Corps centers in every state, the District of Columbia and Puerto Rico. In recent years, the centers have been collaborating more closely with businesses and community colleges. The credentials students earn are industry-recognized, increasing the value to both the students and employers. Nearly 80 percent of Job Corps graduates successfully start careers, including in the armed forces, or enroll in higher education or advanced skills training. But we are also looking to improve the program in the coming years. The Department is committed to producing innovation and continuous improvement within the Job Corps program. We recently released a solicitation to pilot an innovative approach to the Job Corps model at the Cascades center in Washington, and we are preparing for additional pilots in the future. The Department will also launch a major external review of the program beginning in 2016, with the goal of positioning the program for continued success.

Strengthening student safety and security is a top priority. We have initiated a National Safety Campaign – *Standup for Safety* – that includes increased staff training, more intensive center oversight and a requirement that all centers review and strengthen their security procedures. Job Corps has also worked with our students and contractor community to support a student-led *Youth 2 Youth: Partners for Peace* initiative, designed to address youth-on-youth violence, aggression and bullying. We also know we need to make additional investments in mental health counselors and other personnel, as well as structural upgrades to better provide safer, more secure and stable learning environments at Job Corps centers nationwide—the Budget invests in both of these areas.

Since around one in seven Americans between the ages of 16 and 24 are out of both school and work, the Administration is proposing a comprehensive approach to put these individuals on the path to getting a diploma and connecting to postsecondary education and jobs. WIOA also takes an important step forward in addressing this problem by directing that at least 75 percent of Youth formula funds be used for out-of-school youth, while also calling for additional investments for this disconnected and vulnerable population. The Budget proposes \$5.5 billion in mandatory funding to help engage young people in the workforce and set them on a path to a better future. Of this, \$3.5 billion will be used to provide paid work opportunities – bolstering young people’s resumes and giving them the opportunity to gain useful work experience. These youth will also be given the means and support necessary to complete a high school degree or its equivalent, as well as assistance with financial literacy. In addition, \$2 billion will go to local governments in communities struggling with high rates of youth disengagement, high school dropouts and youth unemployment. These resources will help communities locate and reengage youth, providing them with counseling, support services, education and employment opportunities.

As we build a more integrated, demand-driven job training system, we must use data to understand the labor market. The Bureau of Labor Statistics (BLS) is the principal federal statistical agency responsible for measuring labor market activity, working conditions and price changes in the economy. These data are invaluable to decision-makers. To better understand what is happening in the workplace, the Budget includes, among other resources, funding for the first year of activities for a Survey of Employer-Provided Training, which will fill a key gap in knowledge about the workforce system. The Budget also covers inflationary costs to ensure no diminution in the quality of the Bureau's core surveys.

Data on training, careers and jobs should also be more easily accessible. Every year, millions of people begin a post-secondary education. While we know that this can be a crucial investment in one's future, many people choose a school or education track with little information about job placement rates, sometimes leading to thousands of dollars of debt without meaningful job opportunities. We want to empower workers to make smart time and money investments. Thus, we propose \$500 million in mandatory funds for a Workforce Data Science and Innovation Fund that will invest in state data systems so they are able to create easy-to-understand scorecards about outcomes, like job placement, earnings, job tenure and other indicators of success. That way, workers can better compare one program to another and make informed choices about which program is best for them. The Department will also work with the Departments of Commerce and Education to develop new standards, analytical data sets, and open source data products on jobs and skills, so that researchers can do deeper analysis. This type of information will give consumers of education and training the best chance to build a successful career.

Supporting Our Veterans and Long-Term Unemployed

Despite giving years of their lives to our country, far too many veterans struggle with unemployment and even homelessness. The Veterans' Employment and Training Service (VETS) helps veterans and separating servicemembers transition to a good civilian career, starting with a robust and revitalized three-day Employment Workshop that is required for every separating servicemember. These workshops are part of a comprehensive veterans' employment support program, which is anchored in our American Job Centers across the country.

The Homeless Veterans Reintegration Program (HVRP) helps transition homeless veterans into meaningful employment. The Department's FY 2017 request includes an increase of \$12 million to fully fund this program at the authorized level, allowing us to serve more veterans who have struggled mightily in making the transition to post-military life. Our most recent data show that over 68 percent of HVRP participants who completed the program obtained jobs making an average of nearly \$12 an hour. We are eager to expand on this success.

We know the number of long-term unemployed – among both veterans and civilians – remains too high. We can and should be doing more to reach those left on the sidelines during the economic recovery. The data show that people who are out of work for longer periods of time have more trouble finding jobs. The Department seeks to reduce long-term unemployment by continuing to invest in the evidence-based Reemployment Services and Eligibility Assessments

(RESEA) program. In FY 2017, the Budget builds on the increased investments made by Congress last year, including an additional \$70.9 million for a total of \$185.9 million. These dollars will expand services to all veterans receiving benefits through the Unemployment Compensation for Ex-Servicemembers, as well as the one-third of Unemployment Insurance (UI) claimants who are most likely to exhaust their benefits and become long-term unemployed. Research shows that each dollar invested in these services yields approximately \$2.60 in benefits savings, thanks to shorter unemployment duration.

Unemployment is sometimes caused by unnecessary barriers that a worker faces when he or she has to move. The Department's efforts at developing industry-recognized and portable credentials have helped increase labor mobility, but different states often have a wide variety of licensing rules for the same occupation. By simply moving across a state border, trained professionals with years of experience sometimes have to pay high licensing fees or spend months redoing coursework to obtain a job for which they already have the skills. The Budget proposes to build on the resources provided by Congress in FY 2016, investing \$10 million in FY 2017 to identify and address areas where occupational licensing requirements are creating an unnecessary barrier to labor market entry or labor mobility. This investment will be particularly useful to transitioning service members, military spouses, formerly incarcerated individuals and dislocated workers.

Supporting Working Families

As some people struggle with retraining or recertification, others working full-time, minimum wage jobs are still unable to make ends meet. No matter how hard they work, they fall further behind. Many of these people need public assistance and visit food banks just to sustain their families. Often, they are one setback away from financial devastation. The current federal minimum wage of \$7.25 per hour is insufficient to support a family.

The value of the minimum wage, which has not increased in almost seven years, has failed to keep pace with increasing costs of basic necessities. Raising the minimum wage is good for workers, their families and the economy. When minimum wage workers have more money in their pockets, it spurs consumer demand, with that money pumped back into the economy. Congress hasn't taken action, but 18 states and the District of Columbia have raised their minimum wage since President Obama called for an increase in his 2013 State of the Union address. Workers on many federal contracts also now receive higher wages, thanks to an Executive Order signed by the President. Yet there are millions more who continue to struggle. In one of the richest countries in the world, no one working full time should live in poverty.

American workers also struggle with the difficult choice between caring for a new baby or sick family member and a paycheck that the family desperately needs. While the Family and Medical Leave Act allows workers to take unpaid leave without losing their jobs, many families simply cannot afford to take the time off. The United States is the only industrialized nation that fails to offer workers paid maternity leave. Paid parental leave empowers families and produces better outcomes for children. The Department has given out grants to states to research the feasibility of paid leave, and the FY 2017 Budget proposes a \$1 million increase to expand these efforts. But we can do more. To encourage more states to enact paid leave legislation, the Budget includes \$2

billion in mandatory funding for a Paid Leave Partnership Initiative. Under this initiative, the Department would provide funding for up to five states to launch paid leave programs. States that choose to participate in the Initiative would be eligible to receive funds for the initial set up and three years of benefits. The Budget also proposes legislation that would allow federal employees six weeks of paid administrative leave for the birth, adoption, or foster placement of a child. An investment in healthy families is an investment in our nation's future.

Protecting Workers, Wages, and Retirement Security

At the Labor Department, we reject the false choice between economic growth on the one hand and worker protections on the other. While most employers play by the rules, there are too many cases where workers are cheated out of their hard-earned wages or forced to endure an unsafe workplace. At the Labor Department, we are more strategic than ever before about cracking down on wage violations, enforcing workplace safety, and protecting the retirement savings of your constituents who have worked their whole lives to build a nest egg. In doing so, we both protect workers and create a level playing field for law-abiding employers.

Our worker protection agencies have helped recover \$1.6 billion in back wages owed to over 1.7 million workers since 2009. We have prevented catastrophic falls (which lead to days of lost productivity and large workers' compensation payments), reduced workers' exposure to harmful and cancer-causing agents, and awarded over \$150 million to whistleblower complainants. We have made progress in addressing unequal pay for equal work; helped workers with disabilities receive reasonable accommodations; and helped applicants who were denied jobs because of racial discrimination. We have trained small businesses and thousands of workers on mitigating high-risk safety and health hazards. In 2015, we helped mine operators achieve the lowest number of fatalities ever, with underground respirable dust levels in coal mines falling to an all-time low. We have recovered more than \$1.7 billion affecting nearly 700,000 benefit plans and 190 million plan participants.

I am proud of this work. The Budget includes \$1.9 billion so we can continue meeting our responsibilities to safeguard the health, safety, wages, working conditions and retirement security of American workers.

To protect America's workers, we need to make sure their employers compete on a level playing field in the global economy. As part of the Administration's trade agenda, the Bureau of International Labor Affairs (ILAB) is on the front lines helping to ensure that our global trading partners adhere to agreed-upon labor standards, preventing foreign businesses from gaining an unfair advantage on the backs of workers. The Budget includes a \$15 million funding increase for ILAB to promote consistent, effective enforcement of the labor provisions of free trade agreements. And we also seek the restoration of \$5 million in grants, which were reduced in FY 2016 appropriations, to continue (among other activities) preventing the worst forms of child labor.

Protecting workers' retirement plans is a cornerstone of our work, especially given an aging population and the decline of defined benefit pensions. Planning for retirement used to be simple, but today one out of three workers do not have access to a retirement savings plan through their

employers. Contractors and temporary employees are ineligible to participate in employer-based plans. And many workers who move to a new job are forced to manage a number of retirement accounts from previous jobs. Careers may be mobile, but some retirement accounts and savings plans are not.

The Budget includes \$100 million for a mandatory funding proposal to provide grants to states and nonprofits to test innovative, more portable approaches to providing retirement and other employment-based benefits. The goal is to encourage the development of a new model that workers can take from job to job and that can accommodate contributions from multiple employers for an individual worker. The Budget proposes legislation that will allow multiple unrelated employers to come together and form pooled retirement plans, lowering the cost and burden for each employer. In addition, small employers who auto-enroll employees in a retirement plan would receive a tax credit to offset administrative expenses. Until legislation is enacted, we have also taken administrative steps to promote savings. The Department has proposed regulations and issued guidance to facilitate states' efforts to create their own retirement plans for private sector employees. The budget request for the Employee Benefits Security Administration (EBSA) also includes an increase of \$6.5 million to pilot different approaches to increasing retirement plan coverage in states.

The Pension Benefit Guaranty Corporation (PBGC) acts as a backstop to insure pension payments for workers whose companies or plans have failed. Both PBGC's single-employer program and multiemployer program are underfunded, with combined liabilities exceeding assets by \$76 billion at the end of 2015. Premium rates remain much lower than what a private financial institution would charge for insuring the same risk and are well below what is needed to ensure the solvency of PBGC. To address these concerns, the Budget proposes giving the PBGC Board the authority to adjust premiums and directs the Board to raise \$15 billion in premiums in the budget window only from the multiemployer program, given the single-employer program's improving financial projections. This level of premium revenue would nearly eliminate the risk of the multiemployer program becoming insolvent over the next 20 years.

The budget request for the Wage and Hour Division provides resources to enforce laws that establish the minimum standards for wages and working conditions in workplaces across the United States, particularly in industries where workers are most at risk and are least likely to assert their rights. The Budget also expands funding for efforts aimed at ensuring that workers receive back wages they are owed, as well as funding to crack down on the illegal misclassification of some employees as independent contractors. Misclassification deprives workers of basic protections like unemployment insurance, workers' compensation, and overtime pay, and it undercuts employers who play by the rules while their competitors skirt their obligation to provide wages, benefits, and social insurance.

The Occupational Safety and Health and Mine Safety and Health Administrations (OSHA and MSHA) enforce safe and healthful working conditions for America's workers. Across the two agencies, the Budget provides more than \$992 million for these activities. That includes funds for OSHA to bolster the agency's ability to enforce safety and health standards; provide compliance assistance to employers and vulnerable workers; and administer more than 20 whistleblower laws that protect workers from discrimination and retaliation when reporting

unsafe and unscrupulous practices. The Budget will also allow OSHA to enhance safety and security at chemical facilities, and it will provide MSHA with the resources it needs to conduct statutorily required mine inspections and enforce laws that protect miners who report safety or health problems.

Finally, the Office of Federal Contract Compliance Programs (OFCCP) enforces equal opportunity and affirmative action requirements covering federal contractors and subcontractors. OFCCP ensures that their job applicants and workers do not face discrimination because of their race, color, religion, sex, sexual orientation, gender identity, national origin, disability, or veteran status; or because they inquire about, discuss, or disclose their compensation or the compensation of other employees or applicants. The FY 2017 Budget request for OFCCP would allow the agency to continue its current work, while also creating two Skilled Resource Centers and continuing modernization of the core Case Management System. The implementation of the targeted Skilled Resource Centers will allow OFCCP to better align its investigative skills trainings for existing and new compliance officers with geographically concentrated business sector industries. The dedicated funding for the Case Management System would support the continued improvement of OFCCP's enforcement efforts. It will assist in the standardization of the Department's Digital Government Integrated Platform, which is designed to modernize legacy systems within the Department; to support enterprise data analytics and mobile data applications; and to enhance staff productivity and efficiency.

Improving Data-Driven Decision-Making, Creating Efficiencies, and Program Reform

In recent years, the Department has been striving to increase the productivity and efficiency of its own workforce. We believe our mission-driven focus and data-driven performance work have borne fruit. The Department's staff is becoming more effective at their jobs, and this has led to significant improvements in the Department's rankings of best places to work. The Budget includes a number of investments to continue improving the Department's ability to serve the public, increase DOL employee effectiveness, streamline processes and enhance agencies' ability to target enforcement efforts.

The Department continues to work to improve its IT management. Over the past few years, we have consolidated nine separate IT infrastructure components into one consolidated system. Within this system, the Department is implementing a consolidated platform, which will support information-sharing and improve the efficiency and effectiveness of the Department's workforce. The Department's IT Modernization budget includes an increase of \$33 million to further these efforts and to address the security of our systems.

Also, several agencies' budgets -- including the Office of Labor-Management Standards (OLMS), the Office of Federal Contract Compliance Programs (OFCCP), and the Office of Workers' Compensation Programs (OWCP) -- include proposals to upgrade case management or claims processing systems. The goal is to improve the agencies' enforcement targeting, enabling them to better identify those employers who are violating the law. OWCP's 20-year old Longshore and Black Lung claims processing systems are out of date, and the FECA claims system is approaching the end of its life. OWCP is looking to move toward a unified claims-based system that would facilitate more effective delivery of benefits to claimants across the four

programs OWCP administers, while also yielding savings in future years. The OWCP Interactive Voice Response proposal will bolster these efforts by providing a more seamless experience for callers, including improved response from a mobile workforce, leading to shortened processing times. Similarly, OLMS' 15-year-old, obsolete IT system jeopardizes mission critical functions. Modernization would ensure continuity of operations; enable sharing of enforcement data; expand online reporting; improve transparency of union, employer, and labor consultant finances and activities; and dramatically enhance web search and navigation.

Thanks in large measure to the work of our Chief Evaluation Office, the Department has been held up as a leader in data-driven decision-making. The Budget includes an increase for the office, while also continuing to allow for the transfer of resources from agencies for evaluations of their programs.

The Budget also proposes several program reforms. Unemployment Insurance provides critical income support to unemployed workers. After cutbacks in coverage by states and due to broader changes in the economy, about one out of every three unemployed workers receives UI benefits. The Budget includes cost-neutral reforms to both strengthen and modernize the UI program. These reforms will provide additional benefit access to part-time workers, low-wage workers and workers who must leave a job for a compelling family reason. The Budget also helps unemployed workers return to work more quickly; reforms UI to help prevent layoffs; makes the UI program more responsive to economic downturns; and shores up the solvency of state UI programs. Lastly, it proposes to establish a wage insurance program to help workers make ends meet if a new job pays less than the old one.

We are also once again proposing changes to the permanent labor certification program. This is the process we use to certify that an employer seeking to obtain employment-based permanent residency for a foreign worker -- also called a Green Card -- has adequately tested the U.S. labor market, demonstrating that there are insufficient U.S. workers available and qualified for the job, and that no adverse effect on wages and working conditions of U.S. workers will occur. These conditions must be met under the Immigration and Nationality Act before a Green Card is issued. One of our most critical budget proposals would authorize legislation allowing the Department of Labor to establish and retain fees to cover the costs of operating the foreign labor certification programs, helping us improve the speed and quality of certification processing. The Department has heard from businesses across the country that support a filing fee to expedite the process. There is precedent for such authority: under the H-1B visa program for temporary employment in specialty occupations, we use a portion of the proceeds from employer fees to process labor certifications. There are no backlogs in processing applications under that program, despite a 76 percent increase in applications over the last 5 years. The inability to charge a fee to support more efficient application processing and program administration hurts businesses, workers and our economy.

Conclusion

During the time that I have served as Secretary, and throughout the seven years of this Administration, the Labor Department has done important work to expand opportunity to more workers, families and communities. Our efforts have played an indispensable role in the nation's

economic recovery. Continuing and strengthening those efforts requires a strong but responsible budget, which makes smart investments in our nation's workers, job-seekers and retirees. America has no greater economic asset than our people, our human capital. This President's Budget empowers our people, giving them the tools they need to thrive in 2017, and for years and decades to come.

Mr. Chairman, thank you again for this opportunity. I look forward to discussing our budget request with you and all members of the committee, and I'm happy to respond to any questions you may have.

Mr. COLE. Well, thank you, Mr. Secretary.

And just so the committee knows, we extended you a little extra time. We are not going to extend any of us any extra time. So we will—

Secretary PEREZ. You are very kind. Thank you, sir.

Mr. COLE. No, no, that is fine. And we will adhere by the 5-minute rule.

PROPOSED NEW MANDATORY PROGRAMS IN THE 2017 BUDGET

I do want to go back to this issue of mandatory programs, as I told you, because it causes me great concern, and I have seen a pattern of this, if you will, across a number of departments that we have jurisdiction over on this committee. In your fiscal year 2017 budget, you provided minimal detail on proposed new mandatory programs, again totaling, as both the chairman and I pointed out, over \$17,600,000,000.

The committee notes that these proposals exceed the total discretionary funding for the entire Department of Labor for fiscal year 2016 by over \$5,000,000,000. These proposals seem to rely exclusively on creating new grant programs that are neither tested nor authorized by the appropriate committees of jurisdiction.

In fiscal years 2014 and 2015, the department went ahead without authorization or approval of appropriations with similar proposals to create the job-driven training and sector partnerships grant program using excess discretionary funds from the Dislocated Workers National Reserve, amounts intended to support the National Emergency Grant program, technical assistance for efforts such as WIOA implementation, capacity building, and true demonstration projects to test new strategies to improve effectiveness and efficiency of taxpayer investments the across the workforce.

It is unclear from the budget what these proposals intend to achieve and how they would be implemented, and without proposed legislative language or appropriate justification in the department's budget, the committee must assume these proposals are sort of gimmicks, you know, in a budgetary sense. So can you tell me why are these mandatory proposals before this committee, where we have no jurisdiction, rather than the appropriate committees of jurisdiction, and do you plan to present them at some point to the appropriate committees of jurisdiction?

Secretary PEREZ. Well, Mr. Chairman, many of the proposals would require authorization by the HELP Committee or Education and Workforce, but I don't think it is outside of the regular budget process to include legislative proposals in a budget. I know when I worked on the Senate during Republican administrations, we saw that as well during the budget.

I will note that our discretionary budget stayed within the caps. It focuses on our programs that I think we have a lot of shared interest in, investing in skills, making sure we keep the 15 percent reserve authorized, making sure we redouble our investments on homeless veterans' reintegration, making sure we continue to do the work for Native American youth, remarkable work that has been done in ex-offender reentry, which is really, I think, a remarkably exciting bipartisan issue.

Our investments in IT are part of our discretionary budget increase, and we had OMB come in and do a review of our IT system. There are two agencies that have invested less in IT than the Department of Labor, and we see it day in and day out. You know, duct tape is not a viable IT strategy, and all too frequently that is what we are at.

So our discretionary budget seeks additional funding for that, as well as additional funding for enforcement. I talk to employers all the time who are trying to bid on contracts, and they can't because other employers are cheating, and they are not playing by the rules. So enforcement helps that.

WORKING TOWARD AUTHORIZING NEW MANDATORY PROGRAMS

Mr. COLE. Well, again, your discretionary proposals are largely within the caps, as you suggest, and there are many areas, as I have tried to point out in many opening statement, that we will be working with you. But again, you have got mandatory proposals that are beyond the budget of your entire department. None of them have been authorized.

You know, are you going to submit legislation that would actually be authorized because we literally, if we wanted to do that, would not have the ability to give you that kind of authority.

Secretary PEREZ. Well, I would welcome the opportunity to work with you. And let me give you an example.

I mean, we are trying to take apprenticeship to scale, and we very much appreciate the \$90,000,000 that we received. One of the mandatory proposals is to take apprenticeship to dramatic scale because we know apprenticeship works. I have traveled to multiple countries to steal their good ideas and bring them back home. We have developed remarkable opportunity here.

But the reality right now of apprenticeship in America is some States are really moving forward and some States need help. So I would love to work with you on the mandatory budget proposal on that to take it to scale.

Mr. COLE. Well, I have never had any problem on working with you on anything, quite frankly. You are a very willing partner.

But again, you need to work with me. You need to work with Chairman Kline or somebody else because, literally, we don't have that authority here, and I have seen a pattern of this in administration proposals. And I mean, I am perplexed as to why we are setting up expectations for things, particularly in front of this committee, that we simply don't have the authority to do.

So I would just say that as an early warning that I would expect some disappointment from this committee where mandatory spending is concerned because we can't do it, and we just don't have that authority.

With that, I would like to move, if I could, to my good friend, the ranking member, for any questions she cares to ask.

Ms. DELAURO. There was a campaign called "lift the caps." "Lift the allocation" is where I am going with this effort.

HOMELESS VETERANS' REINTEGRATION PROGRAM

But, Mr. Secretary, I want to ask about the Homeless Veterans' Reintegration Program. I talked about Connecticut and what I be-

lieve is really a great accomplishment and ending chronic homelessness amongst our veterans, and we should be proud of that. And nationwide, homelessness, veteran homelessness has dropped by about 36 percent between 2010 and 2015, a great effort by Federal, State, and local officials.

But if we want veterans to maintain stable housing in the long term, they need an income. That requires a job. Happy to see the \$12,000,000 for homeless, the program Homeless Veterans' Reintegration Program. Can you discuss your plans for increased funds for homeless veterans for the program? What kind of progress have you seen in reducing homelessness in our veteran population?

And let me throw in the follow-up question to this, which is the budget also requests a \$71,000,000 increase for reemployment services—

Secretary PEREZ. Right.

Ms. DELAUBRO [continuing]. For UI claimants, and a program that deals with wraparound services for veterans who have exhausted their unemployment benefits. And if you can just tell us about the UCX initiative, how it complements the work you are doing with homeless vets?

Secretary PEREZ. Well, I have traveled the country on this issue because I have had the privilege, until about a couple months ago, for almost 2 years of chairing the Interagency Council on Homelessness. Together with the Secretary of Veterans Affairs and the Secretary of HUD, we traveled the country, shining a light on this. I want to thank all of you for your leadership.

I was out in Phoenix—there is an annual count that is done, a point in time survey. I spent the morning out in the desert with a formerly homeless veteran who had a criminal record, who turned his life around, and has now literally helped hundreds of veterans get work as a result of your investments. So we see it, day in and day out, the work that we have done.

We have seen cities like Salt Lake, New Orleans, and elsewhere, who have eliminated chronic veterans homelessness. We have seen States like Connecticut, who have made progress, and now we have this healthy competition that is going on where we go to one city and say, "Hey, Salt Lake did it. Why can't you?" Or, "Hey, Connecticut did it. Why can't you?"

So we have a series of investments, including the Homeless Veterans' Reintegration Program. My wife works with homeless people here in the District, many of whom are veterans, and what they tell her repeatedly is, you know, "I need a job, and that is one of my best ways to self-sufficiency." That is why those investments are great.

I also want to give a shout-out to a former colleague of yours, Mike Michaud, who is our Assistant Secretary for Veterans' Employment and Training. Mike hit the ground running and has been going gangbusters. When you talk about homelessness, and we have a budget request of \$286,000,000 for our Veterans' Employment and Training Program, all of that money is put to great use.

OTHER COLLABORATION EFFORTS TO HELP UNEMPLOYED VETERANS

You mentioned the reemployment money, that—one thing we know about REA, the reemployment assistance, it works. What we have been doing, if you look at our budget request, we are taking things we know that work and trying to scale them up.

Apprenticeship, we know there is an ROI on that. We know there is an ROI on this reemployment assistance because what people who have been out of a job for a long time need is intensive case management, and that is what this program does. We can cover every veteran who needs it if we can get this budget request enacted, and I can tell you, having worked in partnership with Bob McDonald, Julian Castro, the DOL, DOD, and State and local governments. State and local governments have been so integral to this, and I want to commend as well employers.

I have worked very closely with the U.S. Chamber of Commerce and with labor unions, the Helmets to Hardhats Program. This has been an “all hands on deck” enterprise, and it is Government as facilitator. Our investments are paying a real return.

Ms. DELAURO. I would just say that I would think that given the scale of and the size of the issue with regard to homeless vets and some of the attendant problems, that an opportunity where we have seen success would be where we would want to place some priorities on making sure that we can continue with this kind of successful effort and demonstrate that, you know, we have asked these people to make the sacrifice. They did. They have come back. And now it is our opportunity to be able to—it is not a thank you. It is here is a job so that you can be a productive member of society, which is what you want to be. You do not want to be without a job.

Thank you very much, Mr. Secretary.

Secretary PEREZ. Thank you.

Mr. COLE. We will next go to my good friend, the gentleman from Arkansas, Mr. Womack.

Mr. WOMACK. Thank you, Mr. Chairman—

Secretary PEREZ. Good morning, Congressman.

Mr. WOMACK [continuing]. For yielding time. Mr. Secretary, always good to see you.

Secretary PEREZ. You, too.

PROPOSED CHANGES TO OVERTIME EXEMPTION RULE

Mr. WOMACK. And thanks for your testimony this morning.

Let me just say first that I think I can say pretty confidently that we can all agree that enabling more Americans to reach the middle class is a very laudable goal. However, we must acknowledge if there comes a point where Federal regulations maybe are a little short in accomplishing their stated goal and, in fact, hurt some employers. But across the board, it is usually the employees or customers they serve that get hit the hardest.

And I fear personally that a “one size fits all,” ever-increasing, top-down proposal or answer or regulation affects our job creators. So I want to take some time here this morning to express concerns with the dramatic changes your agency proposed to overtime ex-

emptions, including an unprecedented 113 percent increase in the salary threshold in automatic annual updates.

It would be challenging for any employer to quickly adjust to such an astronomical increase, but especially those running on fixed budgets or thin margins, such as nonprofits, small businesses, and State and local governments. As you know, nonprofits and for-profits have very different business models. In fact, in Arkansas, there are many nonprofit CEOs that don't even make \$50,440, which I would argue goes a lot further in Arkansas than it does, say, in California due to the vast differences in the cost of living.

There is a nonprofit in my district, Independent Living, who does terrific work with developmentally disabled adults in the town of Harrison, Arkansas. Right now, they are struggling to find ways to meet the Affordable Care Act's employer mandate, along with the reality that 80 percent of their employees can no longer use the companionship exemption. Now they will have to face the added burden of complying with new overtime thresholds.

In the comments they submitted to your agency, they noted that if the rule stands as is, they will have to convert salaried employees to hourly, and ultimately, there will be a reduction in services. How can a nonprofit serving adults and children with developmental disabilities in a rural community, Mr. Secretary, continue to provide vital services when faced with drastic increases in administrative costs and few exempt staff?

Secretary PEREZ. The overtime rule stands for the simple proposition that when you work extra, you should be paid extra. I can't get into too many of the details of where it is because of where we are in the process. But what I can tell you is what we did beforehand, which is we spent about a year and a half reaching out, building a large table of inclusion, because I am a big believer that if you are going to do this job well, you have got to be a good listener, and you have to approach the enterprise with a healthy degree of open-mindedness and humility.

So we heard from a lot of different employers. During the comment process as well, we got comments from nonprofits, some of which expressed concern about the proposal, some of which expressed support for the proposal.

I can assure you that I think we got roughly 300,000 comments overall, something like that. We looked at every single one of them and continue to look at every one of them very, very carefully so that we can craft a rule that is consistent with the purpose of the Fair Labor Standards Act, which says that if you work extra, you should be compensated extra.

I spoke to many people who have been working 60, 70 hours a week, and as a result of a change that was made in 2004, they are making effectively the minimum wage because they are not eligible for overtime, even though 99 percent of their work is nonmanagerial in nature. So I am thinking about them as well as we craft a final rule, and I can assure you that when we reach a final rule, we will continue to do what we have done throughout the process, which is aggressively engage all stakeholders, including employers large and small, profit and nonprofit, and explain to them.

Because I learned—and I spoke to a lot of the people who were involved in the 2004 rulemaking during the Bush administration,

and I think it is very important in the aftermath to be out there explaining the various options for compliance because my goal is always to facilitate compliance.

OVERTIME REGULATION IMPACT ON SPECIFIC INDUSTRIES

Mr. WOMACK. Real quickly, and I have got a half a minute left, did the agency take into account the disparate impact it would have on, say, like urban versus rural or businesses or nonprofits that have far-ranging hours, differences in hours from week to week or month to month?

Secretary PEREZ. Again, we received comments from folks all over the country, comments from nonprofits in urban areas, comments from nonprofits and for-profit businesses in suburban, exurban, and rural areas as well, making the point that you are trying to make. That is why the notice and comment period is so important, and we got, again, something like 300,000, and we have reviewed them very, very carefully.

Mr. WOMACK. I thank the gentleman.

Thank you, Mr. Chairman.

Secretary PEREZ. Thank you, sir.

Mr. COLE. Thank you.

We will next go to the gentleman from Philadelphia, my good friend, Mr. Fattah.

Mr. FATTAH. Thank you, Mr. Chairman.

Secretary PEREZ. Good morning, sir.

Mr. FATTAH. Thank you, Mr. Chairman.

Mr. Secretary, it is good to see you again.

Secretary PEREZ. Always good to see you again.

URBAN TECHNOLOGY PROJECT

Mr. FATTAH. And I join with you in commenting that the chairman has worked well to try to make sure that the department's efforts can be supported and on our ranking member. I want to thank you for your extraordinary period of public service, and particularly in terms of your work at the Labor Department. Philadelphia has benefited greatly by your work.

I want to point out in particular a program that you not only found a way to be supportive of, but you have championed around the country, and I want to mention it because I think it is something that other cities and other communities can look at, the Urban Technology Project, which is taking out of school youth and train them to be computer techs and put them back in the schools to fix computers so that the educational process can go forward.

And you not only—I want to thank you particularly for the \$2,900,000 or almost \$3,000,000 grant out of the pool of dollars that you talked about a few minutes ago, the \$170,000,000-plus in apprenticeship. And you are right that these apprenticeship programs, and you funded a host of them around the Nation, have created an impulse that I think won't go away again in our Nation, which is that we need to give young people hands-on experience so that they can, you know, learn what it is to accomplish something and to do difficult tasks, but to understand that they, indeed, can do it.

So I want to thank you for that and so much more. Time won't allow. But I do want to say that I did on social media this morning applaud the department for the work you are doing around this overtime issue that was just discussed with my friend from Arkansas. And I do think that these 5 million Americans who are working more have every right to have the Labor Department take a look at their circumstance to make sure that we are applying the rules as they should be applied, and we know that for a fair day's work you should get a fair day's pay.

So I want to thank you and look forward to continuing to bring you to Philadelphia and bring more checks with you. All right?

[Laughter.]

Thank you.

TECHHIRE APPRENTICESHIP PROGRAM

Secretary PEREZ. Mr. Chairman, the program he is referring to is we have been very involved nationwide in a TechHire program. I was with former Mayor Nutter in Philadelphia when we rolled out an apprenticeship proposal, and we have invested \$175,000,000 not only with the purpose of doubling the number of apprenticeships and facilitating partnership, but also diversifying access to apprenticeship. Making sure that apprenticeship is available in IT, in cyber, in health.

We were out in Illinois with Zurich Insurance, one of the Fortune 500 company. They are now having an apprenticeship program for claims adjusters because apprenticeship model has application everywhere, and we want to make sure that apprenticeship is available in every ZIP code in this country. There are literally 5.5 million job openings right now, and roughly 10 percent of them are in IT, and only a fraction require a college degree or above.

So whether it is with Chairman Rogers in his district, where we took coal miners who were displaced, at the company called Bit Source and developed the "Silicon Holler"—and their motto is "From coal to code"—or whether we are with kids from the Philadelphia public school system.

When my iPhone goes on the fritz, I don't call Apple. I go to my 13-year-old. Similarly, these teenagers who have fluency, we are taking that fluency and turning it into a middle-class career.

So in literally dozens of cities across this country, this program is taking off. It is a partnership with businesses, with educators, with nonprofits, with schools, and our investments are having a catalytic force. We have another grant program that is out on the street now that is going to take that to further scale, and I am very, very excited about what we are doing there.

Mr. FATTAH. Well, we are excited, too. We want you to come to Philly and announce that one also. So—

[Laughter.]

Mr. FATTAH. But let me just say that these 5.5 million jobs that you mentioned that are open and available in our country, you know, we talk a lot about the 72 months, which is great in terms of private sector job growth. The administration has done an extraordinary job.

But we don't count in the jobs created this 5.5 million that are open now. We only count a job created by this administration when

someone fills it, and maybe in some future administration, we will see that if there is a job open, that that is an important notice to our economy and the strength of our economy. But we need to do more, and apprenticeships are a way to get more young people ready to take on these job opportunities.

So thank you, and keep up the good work.

Secretary PEREZ. Thank you.

Mr. COLE. The chair would ask that Members not monopolize all the Secretary's travel time and all of his—

Mr. FATTAH. Chairman—

[Crosstalk.]

Mr. COLE. We have multiple districts we would like you to—

Mr. FATTAH. We have direct flights to Oklahoma City right out of Philadelphia. I made that offer the other day. Mr. Chairman, I made that offer the other day. [Laughter.]

Mr. COLE. You are a popular man, Mr. Secretary.

If I can, we will next go to my good friend from Maryland, Dr. Harris.

Mr. HARRIS. Thank you very much.

Good to see you, Mr. Secretary. Always good to see a fellow Marylander.

Secretary PEREZ. Good seeing you, sir. Yes, absolutely.

H-2B VISA PROCESSING

Mr. HARRIS. But the first issue I am going to bring up, it just seems like Groundhog Day. I mean, every time you come before the committee, I ask you about the H-2B visas. You know, you—coming from Maryland, you know how important those H-2B visas are, especially to our seafood processing industry in my district.

And unfortunately, I am told, and I just want to know if it is true, that, first of all, are these applications supposed to receive a notification—notice of approval or notice of denial within 7 business days? I mean, is that the goal of the department?

Secretary PEREZ. Well, there are two phases of that. There is a lengthy process. You first have to seek a prevailing wage determination, and our goal there is 30 days. Then, once you get a prevailing wage determination, then you seek to have the labor certification. Our goal there is 7 days.

In the day before the budget was passed, in December, in our processing of the H-2B applications, the 70 percent of the—on the prevailing wage determinations, it was taking 30 days. So we were right at our goal.

Mr. HARRIS. And that is you said it is 70 percent?

Secretary PEREZ. No, no. Then with the labor certifications, the other aspect of the process, the average amount of time it was taking was 9 days. Seventy percent were done within the 7-day period.

Then, when the rider passed and the program was dramatically increased, CBO estimated that it was at a minimum doubled, we saw a dramatic increase, and frankly, we fell significantly behind. Because in the middle of a busy season, we were given a whole new set of rules, and told to implement them immediately. We had to stop the program so that we could read the rider, put out guidance, get the new guidance out, get OMB approval, and then implement your new direction.

Mr. HARRIS. Right.

Secretary PEREZ. So that was right in the middle of our busiest season.

Mr. HARRIS. Okay. But you realize that it is getting worse? I mean, in the week of February 5th, the survey from the H-2B Coalition said 12 percent had no determination after 30 days. By the week of February 16th, it was up to 51 percent. By the week of February 22nd, it is 67 percent.

You are not getting better. You are getting worse.

Secretary PEREZ. It absolutely got worse.

Mr. HARRIS. Each season—

Secretary PEREZ. It absolutely got worse. It got worse because of the rider—

Mr. HARRIS. Well, Mr. Secretary—

Secretary PEREZ [continuing]. That was passed, Mr. Harris, sir.

Mr. HARRIS [continuing]. You are spending time to make an overtime regulation, which is something that, honestly, I understand the administration wants to do it. But this is hurting the economy in my district. Your department is hurting the economy in my district by dragging your feet on these regulations.

Now you have a huge budget. You have a \$12,700,000,000 budget. You ought to be able to do what we ask you to do and what the department has set as its goal, which is a 7-day process.

Now April 1st is coming up. If we don't have these seasonal employees by April 1st, either those businesses are going to not do business and not contribute to the GDP, or they are going to go and get illegal people to do, undocumented people to do these, neither of which is a good alternative.

Secretary PEREZ. With all due respect, sir, I do—

Mr. HARRIS. Let me turn to—

[Crosstalk.]

Secretary PEREZ. With all due respect, when you say that we are dragging our feet—

Mr. HARRIS. That was not a question. Mr. Secretary—

Secretary PEREZ [continuing]. I cannot allow that to go unsaid.

Mr. HARRIS [continuing]. That was not a question. It is my time.

Secretary PEREZ. Because we are not dragging our feet, sir. We are trying to follow the new rules you put in in the middle of the process. That is your right.

Mr. HARRIS. Mr. Secretary, I am going to reclaim my time. I understand filibustering, and I reclaim my time. You explained it once. I get it. You are late. You are not getting them done. I get it.

NEW OVERTIME REGULATION

Let me talk about the overtime regulation because you said work extra, get paid extra. What percent of the new—of the employees who are going to be subject to this are getting pay past 40 hours, and what percent are getting—I am not talking overtime pay. I am talking about any pay for the extra hours. What percent? What is it?

Secretary PEREZ. I am not sure I understand your question, sir.

Mr. HARRIS. Well, if you work more than 40 hours, what this new rule says is you have to be paid time and a half.

Secretary PEREZ. Unless you are an exempt employee.

Mr. HARRIS. Are these businesses paying time, but just not time and a half? Are they paying nothing? What percent of these businesses are paying nothing? What percent are paying time or do not pay time and a half?

Secretary PEREZ. Well, again, I don't have specific percentages. I can go back to our NPRM so I get you precise answers.

Mr. HARRIS. What was your gut feeling, Mr. Secretary? And I am actually going to get to a point here. What is your gut feeling?

Secretary PEREZ. Well, there is a substantial number of folks—

Mr. HARRIS. The majority?

Secretary PEREZ [continuing]. Who work. And again, the typical example that we heard was the person working up to 70 hours a week—

Mr. HARRIS. Okay. I am going to reclaim my time once again.

Secretary PEREZ [continuing]. Many making \$24,000 a year—

Mr. HARRIS. Because you said you don't know the answer, which is striking to me that you made a claim if you work extra, you get paid extra, and you can't tell me how many people are actually getting paid extra right now. Not time and a half, but paid extra.

So I am going to just pose a problem here because I have got fast food franchisees come to me and say, you know, the ladder up for some of these people who are from—the typical entry person is from poor neighborhood. They become a manager. They work at the restaurant.

Are we going to have a second round, Mr. Chairman?

Mr. COLE. I would expect so.

Mr. HARRIS. I hope so. Look, then I will yield back the time, and we will get to it in a second round.

Mr. COLE. Okay. I will go to my good friend, the gentlelady from California, Ms. Lee.

Ms. LEE. Thank you, Mr. Chairman.

Good morning, Mr. Secretary. Just on my time, would you like to respond?

Secretary PEREZ. No, I mean, one thing that Congressman Harris and I can agree on, the day of the week. We have seldom agreed on anything else. And I mean that very respectfully, and I will always aspire to disagree without being disagreeable. But dating back to our interactions in State government, we have seen the world very differently, and I respect that.

Ms. LEE. Okay.

Mr. COLE. If we could, let us—there will be another round, and you guys will have an opportunity to have another exchange. So let us try and keep it focused.

Ms. LEE. Thank you, Mr. Chairman.

Thank you, Mr. Secretary.

Once again, congratulations to you. You have done a fine job.

Secretary PEREZ. Thank you.

DOL'S BUDGET FOR FY 2017

Ms. LEE. And hopefully, within the next few months, we will be able to do even more under your leadership. I wanted to associate myself with the remarks of our ranking member and just make a

note that this subcommittee, once again, we are 10 percent below pre-sequestration level.

And so recognizing that, the choices that we make are very, very difficult. And some of the choices, you know, I question also, again associating myself with Congresswoman DeLauro's remarks.

I am pleased, though, to see the increase for Job Corps funding for \$27,000,000. Also the funding stream of \$5,500,000,000 to connect disconnected youth to more educational and workforce opportunities, which is an increase also for the it is called the Workforce Innovation and Opportunity Act. That is an increase of \$7,000,000 for the very successful Reintegration of Ex-Offenders Program.

I wanted to ask you a couple of things with regard to the unemployment insurance, the wage insurance, because I think that is a very important part of the recovery for those who have not benefited from the recovery from the great recession. In the February jobs report, 242,000 private sector jobs were created and a decrease in unemployment rate to 4.9 percent. That is phenomenal.

COMBATING MINORITY UNEMPLOYMENT

But I am also concerned, consistently concerned that the African-American unemployment rate continues to be more than double the rate of white Americans, as well as the Latino unemployment rate at 5.4 percent. So in revamping this unemployment insurance initiative, how will individuals, especially those from communities of color and those who have not benefited from the recovery, how will they gain access to a good-paying job and stay gainfully employed? And how are you looking at the stark disparities in the racial and ethnic unemployment rates for African Americans and Latinos?

Secretary PEREZ. Sure. That is a very important question. As you know, during the depths of the recession, the unemployment rate for African Americans actually peaked at 16.8 percent. It has now fallen to roughly 8.8 percent, which is obviously far better, but not nearly where we need to be.

Latino unemployment is also higher than the national average, and that is why when Congressman Fattah was talking about investments in apprenticeship, we are not only trying to expand the scope of apprenticeship, we are trying to diversify apprenticeship because the program that we visited in the Bay area that day, when we expand opportunity to develop those pipelines to the middle class. I have had conversations with folks at PG&E. You know, the utility industry is undergoing a remarkable transformation. Those are opportunities for middle-class jobs, and we have got to make sure that everybody from every ZIP code has those opportunities.

The President's investments in the My Brother's Keeper initiative is a reflection of the fact that there are chronic opportunity gaps for young men of color that we need to focus on, and I have been very proud to be involved in that.

The work that we have been doing in the RExO grants is some of the most exciting work that I am involved in because, you know, one of the best ways to reduce recidivism is to give people the skills and the job opportunities so that folks coming out of prisons can become part of the community fabric again.

So these are examples of investments, and my parents always taught me that education is the great equalizer, and we have got to make sure that every school in every ZIP code is providing that remarkable opportunity for folks.

Ms. LEE. And Secretary Perez, on the—I am pleased to see the Reintegration of Ex-Offenders, the \$7,000,000 increase, because I think DOL has a good model, and it is successful.

Secretary PEREZ. It is bipartisan.

TARGETED FUNDING TO POVERTY-STRICKEN COMMUNITIES

Ms. LEE. I actually note it is bipartisan. Also targeted funding, the importance of targeted funding into poverty-stricken communities is very important. So what is your take on that?

And come back to Oakland. We are a TechHire city, and Mandela Training Center is the one you were—we want you back.

Secretary PEREZ. If you didn't have a plan in the apprenticeship grant applications to make sure that apprenticeship was available to historically underserved communities, you weren't going to get a grant.

Ms. LEE. Mm-hmm, okay. Thank you.

Poverty-stricken, I have 8 seconds left. Targeted funding into poverty-stricken communities, is that—

Secretary PEREZ. Well, again, the apprenticeship investments, our summer youth job investments, things of that nature are examples of our efforts to get money where we have chronic opportunity gaps. Like Baltimore City last summer, where we were able to get \$5,000,000 of DOL dollars targeted to the zip codes that needed that most.

Ms. LEE. Okay, thank you.

Secretary PEREZ. Good morning.

Mr. COLE. Would you like to revise your budget to get additional travel money so you can—

[Laughter.]

Secretary PEREZ. I would very much appreciate that. I will take the bus—

Mr. COLE. That makes bipartisan sense, Mr. Secretary.

Secretary PEREZ. I will take the bus if necessary if we can get to more Members.

Mr. COLE. If we next can go to my good friend from Virginia, who, sadly, we will be losing. I regret that every time I have the opportunity to call on him that he is not going to remain in Congress past this year. But he will make every minute count. So my friend from Virginia is recognized.

Mr. RIGELL. Well, thank you, Mr. Chairman. It is good to be here.

Secretary PEREZ. Thank you for your service.

MANDATORY VS. DISCRETIONARY SPENDING

Mr. RIGELL. It is a privilege to serve on this committee.

Secretary PEREZ. Thank you for your service, sir.

Mr. RIGELL. Thank you, Mr. Secretary. Good to see the passion for your work, and I respect and I appreciate it.

I do try to start out generally with what do we have in common, and there is much that we do have in common. I think the appren-

tice program, I really respect that. I have seen it work, and so I applaud you for that.

I do need to quickly pivot to something that there is a serious disagreement on, and that is this—this propensity to shift things over into mandatory spending. Just like we are all in this room here today, we are all in this together with respect to our country's fiscal situation. And I really don't think it can be overstated.

And I think both parties, it is not—this isn't a time and place to debate how we got there, but I really think we have got about a 10-year window to get this right, and it is closing. And it really sober me. And so the voting card that I have in my pocket, there is almost a fixation in this institution on the discretionary side that we largely can't address the mandatory side.

And it may surprise my colleagues on the other side, but as a business person who has transitioned into public service, I really don't see that the discretionary side is what is driving our fiscal situation. And I would be willing to lift them to a reasonable degree, provided, of course, that we had substantive and real, genuine reforms, as President Obama himself has said need to be done, if that could be implemented.

So I just say that as a word to all of us. That has to be done. But for that reason, I wouldn't support the transition and the movement of spending into the mandatory side. We just—we have demonstrated an inability to do what must be done to do what is right for the next generation.

FIDUCIARY RULE

Let me pivot to something that has really come up consistently in Virginia's Second Congressional District, and that is the fiduciary rule. I rarely have seen an issue generate so much attention in, frankly, meetings with me across our district and, indeed, up in Washington about this.

And there is just a troubled look in the advisers that I see. They are good men and women. They love our communities. And you know, we go to church with them or we see them in the grocery store, and they are out there in our communities, and they are deeply troubled by this fiduciary rule.

And I think, for example, when we see that Morningstar, the organization, that rating group, they have actually more than about doubled their estimate as to what your own Department of Labor said the impact would be on that.

So I think that you are underestimating the impact of it, and would you address specifically, if you are familiar with it, the outside group's assessment that the impact is far greater than what Department of Labor has indicated that it would or believes it to be?

Secretary PEREZ. Well, first of all, again, thank you for your dedicated service. It has been an honor to interact with you.

There are few issues that I have spent more time on in my tenure than the conflict of interest rule. When I was nominated, I was asked a lot about this, and I made a commitment, and the commitment was this. I would slow the process down. I would build a big table, and we would listen and listen long and hard.

I can look you in the eye with a fair degree of confidence and say every time I got a call from a Member of Congress, Republican or Democrat, who said, "Can you talk to so and so from my district?" we did that. It was either me or someone from my staff, and more frequently, it led to more than one conversation because we always got smarter as a result of those interactions.

The conflict of interest rule is a reflection of the fact that in our Ozzie and Harriet era of our parents, this conversation was irrelevant because people worked 30 years. They had a defined benefit plan. They would get a pen, a party, and a pension when they retired. And now in the world of IRAs and 401ks, people have to take control of their universe.

I very much agree with you when you said that the folks who are in this industry are good people. This is not about folks who wake up with malice in their heart in the morning. This is about a system where the incentives are not properly aligned with the best interests of the consumer.

Mr. RIGELL. Well, I have——

Secretary PEREZ. And that is what we have heard consistently. And I welcome——

Mr. RIGELL. I have got maybe about 40 seconds left. Let me, if you would, pivot over to the difference between Morningstar, for example, outside respected groups and their assessment of the fiscal—I mean, the financial impact of this versus Department of Labor's. There is a great disparity between the two.

And it has been my experience and I think just by observation we can conclude that generally the impact of Federal regulations are underestimated, not overstated. So here we go again, I believe.

So in the 10 seconds, go ahead.

Secretary PEREZ. Sure. Real quickly, we have received a voluminous amount of comments, both in the formal comment period and before, including from Morningstar, including from other folks who are already fiduciaries who support this rule. What we are in the process of doing right now, and it was over 300,000 comments there as well, is taking all of those comments into account to craft a solution, and we have made a commitment to doing that outreach.

Mr. RIGELL. I thank you. I am a little over, and I want to respect the chairman's commitment to the 5-minute rule. But I thank you for your testimony.

Mr. COLE. It is thoughtful questions like that in a manner like that is exactly why my friend should reconsider and run for reelection. [Laughter.]

Mr. RIGELL. You should talk to Mrs. Rigell. [Laughter.]

Mr. COLE. I think I would lose that debate.

Next I would like to go to my good friend from Alabama, Mrs. Roby, for whatever questions she would care to offer.

Secretary PEREZ. Good morning, Congresswoman.

Mrs. ROBY. Thank you, Mr. Chairman. Good morning.

Secretary PEREZ. Good to see you again.

PAID LEAVE PARTNERSHIP INITIATIVE

Mrs. ROBY. You as well. The fiscal year 2017 budget for the Department of Labor requests \$2,200,000,000 in funding for the ad-

ministration's Paid Leave Partnership Initiative. They are going—these funds are going to be used to fund five States selected to implement this paid leave program to support leave requests under the Family Medical Leave Act.

It would provide 50 percent of the cost to launch these paid leave programs for 3 years. The grant could be used to cover family, parental, or medical leave programs that provide up to 12 weeks of benefits.

So the Department of Labor mentions that grants will be awarded competitively to States that are well positioned—"well positioned to proceed with full implementation of a paid leave program." Please explain to us what "well positioned to implement a paid leave program" means.

And to follow up with that, explain how these well positioned States will cover the entire cost of the program after the 3 years.

Secretary PEREZ. Well, thank you for your question.

The United States is the only industrialized nation on the planet that doesn't have some form of Federal paid leave, and we have seen the consequences of this. People talk about the need for higher labor force participation rates. If we had a paid leave system like Canada did, we would have more women in the workplace.

Mrs. ROBY. What does it mean to be well positioned to—

Secretary PEREZ. Well positioned means you have the partnerships in place. You have the political will to move forward. You have begun the actuarial analysis.

A number of States that have put in place paid leave systems, California was the first, and employers don't pay anything. It comes out of the employee. They use the temporary disability insurance system. So—

Mrs. ROBY. What about the other 45 States? To me, this seems like another bait-and-switch scheme where you are going to fund these programs for 3 years, and then what happens to sustain it after?

Secretary PEREZ. No, it is—actually, for instance, the State of Connecticut is looking right now at building a paid leave system, and we have been providing technical assistance to them. They are well placed to, I think, move forward, whether it is this year or next year. It is not at all a bait-and-switch system. It is a system that provides an incredibly important benefit for parents who are oftentimes giving birth on a credit card because they have got to go right back to work after.

WORKING FAMILIES FLEXIBILITY ACT

Mrs. ROBY. Well, this is a great opportunity, as I have mentioned to you before, to bring out the Working Families Flexibility Act, which is legislation that I have introduced in the past two Congresses, which would amend the Fair Labor Standards Act to allow employers and employees to enter into a voluntary agreement whereby hourly wage employers could convert overtime pay to compensatory time off.

My proposal is not an unfunded entitlement, which I believe is what the Paid Leave Partnership Initiative is. But my legislation allows hard-working families the flexibility to use their hard-earned money in ways that they see fit. And if they need time off,

it is there, and there is cash out provisions that protect the employee to ensure that they can get the cash, if that is what they ultimately determine.

So, Mr. Chairman, I know that you and many others on this committee have supported H.R. 465. I hope we can all understand that commonsense solutions, like the Working Families Flexibility Act, are the best options given our fiscal outlook as a Nation, not unfunded entitlement schemes like the Paid Leave Partnership Initiative.

And I want to quickly pivot here to ask you about the voluntary—hold on just a second so I don't spill my coffee.

[Laughter.]

Secretary PEREZ. That is very important.

Mrs. ROBY. It is. It is.

Secretary PEREZ. Been there, done that.

OSHA VOLUNTARY PROTECTION PROGRAMS

Mrs. ROBY. The VPP programs, and I have discussed this with you before. The fiscal year 2017 Department of Labor budget request states that OSHA will continue to improve the Voluntary Protection Program in fiscal year 2017, with special emphasis on program consistency and oversight, data integrity, and reevaluation of policies for VPP sites with injury and illness rates higher than industry averages.

So has the Labor Department produced a report, which evaluates the effectiveness of these OSHA compliance programs?

Secretary PEREZ. Well, we very much support the program, and what we have done now, we have 1,400 Federal VPP sites. In fiscal year 2015, we exceeded our goal, and we approved 315 sites and brought 70 new sites into the program. We have worked with folks in Republican and Democratic districts because this isn't red or blue. This is red, white, and blue.

Mrs. ROBY. With 5 seconds left, I just want—I want a commitment that you will submit a report to this committee.

Secretary PEREZ. Sure. I will also have OSHA, you know, the head of OSHA come and visit you and talk about where we are at in the program so that you can get not only a specific accounting of where it is going, but where it is going in your particular district as well as the Nation.

Mrs. ROBY. I would appreciate that. I yield back.

Thank you.

Mr. COLE. Thank you.

We next go to my good friend from Tennessee, Mr. Fleischmann, for any questions he would care to submit.

Mr. FLEISCHMANN. Thank you, Mr. Chairman.

Secretary PEREZ. Good morning. Good to see you.

Mr. FLEISCHMANN. Good morning, Mr. Secretary. I am sorry I was late. I was at another hearing.

Secretary PEREZ. No, that is multitasking.

Mr. FLEISCHMANN. We have got multitasking, but it is always good to see you.

Secretary PEREZ. Good to see you, sir.

PROPOSED RULE CHANGES TO EEOICPA

Mr. FLEISCHMANN. And I thank you for your service, sir.

Mr. Secretary, the Office of Workers' Compensation Program has published the Notice of Proposed Rule Changes to the Energy Employees Occupational Illness Compensation Program Act. This affects a lot of our workers in Oak Ridge——

Secretary PEREZ. Right.

Mr. FLEISCHMANN [continuing]. Who from the Manhattan era have been exposed to a lot of things during the years, and there is a lot of chronic illnesses, sir. I would like to ask a series of questions to clarify these proposed changes.

Secretary PEREZ. Sure.

Mr. FLEISCHMANN. The proposed rule changes alerts medical providers that the Department of Labor may adopt the home health prospective payment system, which was devised by the Centers for Medicare and Medicaid Services within HHS. First question, sir. How would the proposed rule change, if implemented, alter the existent method of paying for home health services, and how will it affect the quality of care?

In other words, will the payments to healthcare providers be less than they are currently, or will fewer services be authorized? Will payments for the same services be delayed, sir?

Secretary PEREZ. Right now, we are in the middle of the rule-making process on that precise rule, sir. We have received a number of comments on that, including issues relating to your questions. So, at the moment, we are reviewing that because it is a very important question, and we have gotten a lot of feedback from a number of key stakeholders.

So I don't have an answer to that right now because we are reviewing the feedback to figure out how we put the rule, the final rule in place. But our overall goal in this is to build a fair system that helps the workers who have suffered and improves the adjudication process to make it, you know, again fairer and more efficient.

Mr. FLEISCHMANN. Would you agree with me, Mr. Secretary, that if you altered it in the way that I alluded to in the first question that it would be a disincentive for providers to participate in the healthcare and management of sick workers, many of whom have several chronic medical problems?

IMPACTS OF PROPOSED EEOICPA RULE CHANGE

Secretary PEREZ. Sure. Sir, I have personally met with a number of folks who have suffered as a result of workplace exposures in various contexts. We owe it to them to make sure that we build a system that works for them and a system, frankly, that works for providers as well, because it is hollow to say you have a right if you can't get to a provider.

Mr. FLEISCHMANN. Thank you, sir.

Some providers in the area do not accept Medicare. Does it, therefore, make sense to apply Medicare payment standards to a program which is supposed to supplement medical services for disease-ridden atomic energy workers?

Secretary PEREZ. Sure. Well, again, that is another one of the comments that we received and we are reviewing, and I think it is a very, very important question, which is why we take it very seriously. Because we are in the rulemaking process right now, I can't get too much further down the road, other than to say that we take that very seriously and we very much appreciate—I know you have had a continuing—you have been a great leader for folks in the community on this, and we have appreciated your engagement.

Mr. FLEISCHMANN. Thank you. Thank you.

If I may, Mr. Secretary, what input, if any, did the Department of Labor receive from local doctors, for example, in the east Tennessee area, if you know, or from home health agencies in formulating any of the proposed rules relating to medical services? Does the Department of Labor know if such providers would be willing to agree to provide services under the home health prospective payment system, sir?

Secretary PEREZ. Well, I don't know—what I do know is that we always aspire and I think we do a pretty good job of building a big table so that we hear from everyone.

What I would offer to do is to make our head of the Office of Worker Compensation Program available to come and talk to you and, to the greatest extent that he can, you know, talk with real granularity about the situation, especially as it affects your community. Because you obviously have strong equities in the resolution of this.

Mr. FLEISCHMANN. Thank you.

And I am cognizant of the fact that you are in the rulemaking process, but are there any provisions in the proposed rule changes which would limit physician choices by beneficiaries? Section 30.405(b) appears to do that. This is concerning because some of the beneficiaries have multiple health conditions, which require treatment from multiple specialists, sir.

Secretary PEREZ. Well, sometimes there are proposals that are out there that people perceive as having an impact one way or another, and that was one example that you cite. And so we are certainly aware of that concern and in our rulemaking process very much attuned to that. And again, I think our director, if you want him to come by, we can have a much longer conversation about that and so many other issues.

Because here is the bottom line. We want to get this right. We want to do right by the folks who spent their career in public service and now have some serious health issues. We owe it to them to make sure that we have a system that treats them fairly. And you have remarkable insights into how we accomplish that goal, and so I want to take advantage, frankly, of your perspective.

Mr. FLEISCHMANN. Thank you. Well, Mr. Secretary, I want to thank you for your commitment to working with me and to help our affected workers in Oak Ridge because they have sacrificed. They are suffering.

And with that, I thank you. And Mr. Chairman, I yield back, sir.

Mr. COLE. Thank you very much.

WORKFORCE INNOVATION AND OPPORTUNITY ACT

Mr. Secretary, one of the challenges we often have in government at all levels and all departments is, you know, we focus on a lot of different things, and sometimes we don't get some of the tasks that we need to get done in a timely manner.

The Workforce Innovation and Opportunity Act, as you have mentioned several times, was enacted in July of 2014, overwhelming bipartisan support. Really one of the great work products Congress and the administration working together produced, and I certainly appreciate your role in that. The act included many reforms intended to consolidate and improve the workforce development system.

The committee is concerned that the department continues to miss statutory implementation deadlines despite the fact that appropriations for technical assistance funds to implement the law have actually been provided in excess of the amounts requested by the department. In addition to funds already provided totaling \$25,000,000, the department requests an additional \$26,000,000 in technical assistance funds for the fiscal year 2017 budget.

Can you tell me whether or not the department will be able to finalize the regulations implementing WIOA before the end of the year? And then what is the proposed use of the technical assistance funds in fiscal year 2017 if the law is, indeed, fully implemented?

Secretary PEREZ. Let me say at the outset, WIOA is one of my favorite pieces of legislation to have had the privilege of being involved in. It is a game changer. And it is a bipartisan game changer.

We expect to have the final rules in place by the end of June, and the process that led us to there has been a remarkably inclusive process. I used to work in local and State government, and the instruction I gave to my team is we need to listen and then listen some more and listen some more to our State partners because they are going to have a lot of insights.

The rules are voluminous, 1,800 pages. We built a big table. Our career folks, they worked through Thanksgiving and Christmas of last year to get all those things out. The vast majority of the act, Mr. Chairman, is actually already implemented as of July of last year.

FINAL WIOA IMPLEMENTATION

What remains to be implemented are the accountability systems there put in place and the State plans, and the good news there is because we have been working throughout with the States, over half the States already have draft plans. The big purpose of WIOA was to implode silos and stovepipes, make sure that the workforce people and the education people and the HHS people are working together.

So today, for instance, 40 States, 4 outlying areas, they already have the new State boards that WIOA called for. We have shared 41 pieces of operating guidance, 28 webinars that we have conducted. I just went to the conference that I used to go to in D.C. about 8 weeks ago in the middle of the storm. Every State except

one was able to make it, and there is a tremendous energy out there.

I want to say thank you to you and your staff because we have been working on this together with Republican and Democratic staffers in the House and Senate. I am excited about where we are. The silo busting is in full force, both in the Federal Government, where we have been working better than ever with Department of Education and HHS and others, and now at State and local governments.

That is good because people don't have a labor issue or an education issue. They just want a good job, and they want the skills to compete. So I am excited, and we will have the final rules in place by end of June.

Mr. COLE. That is good to hear because I think finishing this up, I mean, as you pointed out, the administration has only got about 10 months. I think it would be—

Secretary PEREZ. Three hundred eleven days, but who is counting?

Mr. COLE. Yes, but you would want to get this done.

Secretary PEREZ. I absolutely do.

TECHNICAL ASSISTANCE BUDGET REQUEST

Mr. COLE. If that is the case on that, what are the additional employees—I think you asked for 17 additional folks and \$26,000,000 additional. Is that necessary?

Secretary PEREZ. Oh, the work—yes, I mean, the work is—I mean, we have done a lot, but the work is just beginning. So, for instance, we are trying to build data systems now so that the data system in the State Department of Education can talk to the data system in the State Department of Labor, can talk to the data system elsewhere.

Because we want to track, for instance, wage data. And we did that in our programs, but the adult ed folks didn't do that. And so the work that we are doing and the resources that we seek is to make sure that we can continue the stovepipe implosion process, and it is—it is a formidable challenge when you are trying to build one big sandbox.

Mr. COLE. Well, good luck on that. I have seen Department of Veterans and Department of Defense work on this my entire career and not get it done. So—

Secretary PEREZ. I hear you.

Mr. COLE [continuing]. I wish you well in the technical endeavor.

With that, I want to go to my good friend, the gentlelady, for the next round of questioning.

Ms. DELAURO. Thank you very much, Mr. Chairman.

DOL APPRENTICESHIP AND REEMPLOYMENT PROGRAMS

Just a couple of comments, and then a question that I have on wage theft. Let me congratulate you on the apprenticeship program. Europeans have been doing this for years. It not only is a vision for what we should do, but what we can do with Federal resources in this area.

Secondly, Reintegration of Ex-Offenders. I was at the New Haven Correctional Center just about 2 weeks ago, and soon they are

going to open up through the funding, through the Workforce Alliance, the opportunity for the Department of Labor and these offenders, who are ex-offenders who are getting ready to leave and how we can help to get them employed and be able to pay taxes.

H-2B VISA PROGRAM

A short word on the H-2B visa program. The Labor, HHS bill added several riders, which made the program more complicated to implement, weakened protection for workers in those H-2B industries. First, riders that require the department to use private wage surveys to set prevailing wages caused a delay in processing H-2B applications. We should not shift the blame for the backlog that was caused by this Appropriations Committee.

Another rider blocks the department's ability to audit an employer's H-2B application. The Inspector General has said that this rider will make it more likely that fraud will exist in the H-2B program through no fault of the department.

Let us be real. This is a problem that was caused by the Congress and by this committee. It is not the Department of Labor's fault.

WAGE THEFT

Now my question on wage theft. It has become an epidemic, Mr. Secretary. According to a recent three-city survey conducted in Los Angeles, New York, Chicago, two-thirds of workers in low-wage industries experienced at least one pay-related violation in any given week.

Research estimates the loss per worker over the course of a year, \$2,634 out of total earnings of \$17,616. This is particularly harmful when workers are already economically distressed. Tomorrow, I will introduce a comprehensive bill to address wage theft with Senator Murray.

Can you tell us how widespread this problem is, resources needed at Wage and Hour to tackle the wage theft? You propose hiring an additional 300 investigators to staff the Department of Labor's Wage and Hour Division. Is that enough? And what about the fines? Are they sufficient enough to deter folks from making these unwise decisions to violate the law?

Secretary PEREZ. Wage theft is a huge problem across this country, and let me give you one example. We commissioned an independent study that focused on two States, California and New York, and found that just in those two States, the amount of wage theft approached \$1,000,000,000 a year, just in those two States. Not surprisingly, heavily concentrated on lower-income workers.

These are folks who are not making enough money to feed their family in a good week, and then to have your wages stolen, effectively, adds insult to injury. That is why we have had a very concentrated focus on making sure that we are doing our level best in this context.

By the way, we hear from employers all the time who say thank you because they are playing by the rules. They are paying their folks above the table, and their competitors aren't. That creates an unlevel playing field. So this is not only good for workers, but this is rewarding employers who play by the rules.

That is why our budget request seeks an increase so that we can do more in the Wage and Hour enforcement context. Because it is critically important. It is a chronic challenge in sectors across America, and that is why we have been so laser focused on this.

Ms. DELAUBO. My understanding is that the fine for violations and repeated violations is about \$1,000.

Secretary PEREZ. Well, we have been using—we have been making more use of liquidated damages, but all too frequently, I mean, the challenge that we encounter is it is a cost of doing business enterprise. Actually, what we will do sometimes is we will conduct an investigation, and we work very closely with a number of State partners.

Then, at the end of the day, we may have our State partner move forward because sometimes the State law actually is better than the Federal law. More often than not, it is not.

And frankly, in the State of Florida, under former Governor Bush, they actually eliminated the wage and hour enforcement. So there is no State partner down in Florida, which puts more onus on us to be moving forward. That is why this work is so critically important.

Ms. DELAUBO. Thank you, Mr. Secretary. Let me just say I am glad to hear you say that Connecticut was well positioned in terms of their paid family leave.

Secretary PEREZ. Very hopeful.

Ms. DELAUBO. Very hopeful. Thank you.

Mr. COLE. Would you like to invite him to come to Connecticut?

[Laughter.]

Ms. DELAUBO. I have, and he has come to the State of Connecticut.

Secretary PEREZ. You can invite me to Oklahoma, too, sir.

Mr. COLE. Absolutely. Absolutely. We are going to—you know, you are going to have a lot of frequent flyer miles when you leave.

Secretary PEREZ. That is right.

Mr. COLE. Next we will go to my friend Mr. Harris from Maryland for the next round.

Mr. HARRIS. Thank you. Thank you very much, Mr. Chairman.

Okay. I will just make one comment, and it is not a question. Last year, because I was trying to reflect, what were we talking about last year about H-2B, and it was the court's fault last year. So you came in and said, look, it is the court's fault. We had this court case, the court's fault.

So let me see. Last year, it is court's fault. This year, it is Congress' fault. Does it go back to court's next year, or does the Labor Department—and this is a rhetorical question. Does the Labor Department ever take responsibility for the delays in the H-2B program?

I just have to ask. There is an emergency—and this is a question. There is an emergency procedure. You can submit an application in an emergency procedure.

I am going to assume that if it is under an emergency procedure, you might really want to try to hit the 7-day processing deadline or goal. But in the latest survey, 46 percent of the emergency appli-

cations weren't completed, didn't receive a notice of approval or notice of denial within 7 days.

So how does an—I just have to ask you. How does an employer get their employee in place for an April 1st seasonal start? If the regular procedure has 67 percent more than 30-day wait, the emergency procedure is almost half, 7 days, and 7 days the goal, does the department have a plan on this?

I mean, or it is just we really don't care about H-2Bs because there are other special interests that don't want H-2B workers in the country?

Secretary PEREZ. We do care about H-2B, and we care about the full and effective enforcement of H-2B. When we get the assembly line doubled or as much as tripled on December—

Mr. HARRIS. Mr. Secretary? Mr. Secretary?

Secretary PEREZ. Sir, okay—

Mr. HARRIS. Mr. Secretary, let me just back you up here because I am going to have to stop you when you say things like, you know, work extra, pay extra. Double or triple.

Secretary PEREZ. Sir?

Mr. HARRIS. Do you have a tripling in the number of applications this year?

Secretary PEREZ. I will give you the specific data on the number of applications that we got, okay?

Mr. HARRIS. Did it triple?

Secretary PEREZ. Absolutely. I will tell you the exact—

Mr. HARRIS. Did it triple?

Secretary PEREZ. Double or triple is what I said. I will get you the precise data. The problem, sir, is you told us to do twice as much work with the same amount of resources.

Mr. HARRIS. So it is twice the number of applications?

Secretary PEREZ. I will get you the numbers, as I stated, sir.

Mr. HARRIS. Is that your testimony today? The number is twice?

Secretary PEREZ. I told you—my answer for the third time is that I will get you the precise data. The applications doubled over late December and early January. We had the same resources to process those applications.

I accept responsibility for the fact that we are trying to do our best, and sometimes we have issues like IT. But you know what, sir? I think there is rather than playing the blame game, I think what we should try to do is fix the system because we did make a commitment a year ago that we would have a rule in place by the middle of April.

I made that commitment to Senator Mikulski and others. And guess what? We made that commitment, and we put a rule in place by the middle of April. And Congress gave us a new rule on December 16th, told us, you know, implement immediately. No new resources, but implement immediately.

We read it. We put a new system in place something like 17 days later because we did want to read what you told us to do. When we did that, it absolutely resulted in delays. Delays will result in mistakes because we have the assembly line moving faster.

The Bush administration rule had an audit function in 2008 because they understood that you needed to make sure you had an

audit system in place so that it was a check on the fact that the assembly line was moving fast. This was taken away.

So when we have folks who get those certifications and they were in error, the audit function, we can't correct that when it is done. That is the reality of our world.

Mr. HARRIS. The reality of my world is, is that my employers are not going to have workers in place because the hang-up was DOL, period, full stop. The hang-up was DOL.

PROPOSED FY 2017 MANDATORY BUDGET

Now let me ask you about because I also have concerns what the full committee chairman said about this tendency to go to mandatory, to expand the number—the last thing this country needs are more mandatory expenditures, the last thing. So I have got to ask, so I look at some of these programs, say, you know, for some things, maybe mandatory makes sense because you got to even out, you know, the year-by-year variation.

But one program is the mandatory funding to provide summer—I am sorry, yearlong first jobs to 150,000 opportunity youth. Now these are yearlong jobs. These are not 4-year jobs or 5-year jobs.

So to the untrained eye, it would look that the only purpose of making this a mandatory expenditure not subject to annual appropriations is to get around the spending caps because these are yearlong jobs. These are not 2-year long jobs. These are not 5-year science, cancer science research projects. These are yearlong jobs.

Simple question, Mr. Secretary. Why can't that be subject to annual appropriations?

Secretary PEREZ. Well, sir, we have a serious youth unemployment problem. Congresswoman Lee asked a very important question about the fact that zip codes all too frequently are determining destiny in this country. When you look at the history of this Congress' investment in young people, it was a far more robust history and a bipartisan history in recent years, and we have to ensure that we address these issues of chronic poverty and the absence of opportunity.

I respect the fact that we have a different perspective on that, but that is certainly my strongly held view.

Thank you very much.

Mr. HARRIS. Thank you.

Mr. COLE. I would ask that we, in fairness to the Secretary, not push the questions to 2 seconds before the expiration of time because he deserves a chance to answer. And we have got few enough people here. We will have an opportunity to go around again if we need one.

With that, let me go to my friend Mr. Dent from Pennsylvania and for whatever questions he cares to pose.

Secretary PEREZ. Good morning, sir.

Mr. DENT. Good morning. And thank you, Mr. Chairman. I apologize for being late. I had another hearing this morning.

OSHA RETAIL EXEMPTION RULE

Mr. Secretary, in December, Congress—and the Congress passed and the President signed into law the omnibus appropriations bill, which included language in the joint explanatory statement that

prohibited OSHA from using funds to enforce the July 22, 2015, retail exemption memo unless OSHA went through notice and comment rulemaking.

On December 23, 2015, just 6 days later, OSHA issued a memo that delayed enforcement of the memo until the first day of fiscal year 2017, which is a good thing. However, simply delaying enforcement is not what Congress directed the agency to do. Why has OSHA decided not to go through a proper public notice and comment rulemaking on this so-called retail exemption?

Secretary PEREZ. Congressman, I think we did comply with the rider, and we did extend the effective date to October 1.

The context of this issue, and I very much appreciate your question, is the horrific incident that occurred in west Texas, where there was a dramatic explosion that killed 15 people, mostly first responders. If it had occurred in the middle of the day, there would have been schoolchildren who died because it leveled the school. Fortunately, nobody was there.

As a result of that incident and other recent chemical plant catastrophes, the President issued an executive order that directed us to enhance safety and security in our chemical facilities.

So we were very motivated by the fact that we had first responders whose lives were taken there, and we wanted to prevent such a thing in the future. We carefully considered, and by the way, we did receive comment on the guidance that we put out because we certainly valued that.

But the first responders were very much on our mind, and you know, we have had other litigation that addresses the question that you ask about whether we can—whether we have the ability to do guidance here. The Supreme Court in the mortgage bankers case did uphold our ability to do guidance, and the matter is in litigation. We will obviously respect whatever the outcome of that case is.

But I wanted to give you an understanding of why we chose this route. We wanted to make sure that we could prevent as soon as possible another catastrophe.

IMPACT OF PSM COMPLIANCE

Mr. DENT. Yes, and certainly safety is on the forefront of all of our minds in respect to this tragedy in Texas and elsewhere. But I have been hearing from a lot of my farmers and agricultural retailers who tell me that they are getting out of the anhydrous ammonia business because of the significant cost and burdens of complying with the process safety management, the PSM.

My concern is that fewer facilities carrying anhydrous ammonia could actually have adverse safety effects. Farmers and retailers are going to be forced to travel much longer distances on the road to get this anhydrous ammonia to the farm and/or anhydrous ammonia will be stored at entities which are not going to be regulated by OSHA.

That is my concern on the safety, that this stuff is going to be stored elsewhere. People are making—the farmers and the agricultural sector making much longer trips to move this stuff, to get it to the farm. And I am not sure that that is going to lead to greater safety. So I would be curious to hear your comments on that.

Secretary PEREZ. Well, we heard a number of different comments during our period when we were soliciting comments, and we heard from a lot of first responders who indicated that a big concern of theirs was what I have described. We have continued to work very close with industry, and I would be more than happy to, if there are folks in your district, I want to make sure—we have a shared interest in getting it right.

Nobody has a monopoly on the commitment to safety—

Mr. DENT. We want to do the right thing.

Secretary PEREZ [continuing]. And we all want to do the right thing here. So I would be more than willing to figure out a way to work with you to see if there are things that we should know that we don't know because I am never—again, you have got to bring some humility to the enterprise. So if you have other things to bring to our attention.

Mr. DENT. That would be very helpful because the PSM standard requires manufacturers and distributors to develop and implement a PSM program any time they have at least a minimum amount of highly hazardous chemicals involved in a process, including storage. So I guess what the question is, and you just offered it, that would be great if OSHA could hear from some of the stakeholders through the public comment and review period.

That would be very, very helpful. I think they need to be heard on this because, I said, we want everybody to be safe. But I am worried about farmers going greater distances, going to remote locations to pick up this material, and we are going to have safety issues.

Secretary PEREZ. Well, then we are committed to not enforcing it in this fiscal year, and we are also committed to continuing to work very closely with industry and with other stakeholders like yourself because we all want to get it right.

IMPACTS OF OVERTIME RULE

Mr. DENT. Just a final comment, too, and my time is up. Just—you don't have to respond. I know you talked about the overtime rule. I just wanted to mention that this issue is creating a lot of hardship for my not-for-profit sector in my district. When my YMCAs call me and say doubling that exemption to \$50,000 a year is creating real hardships in terms of managing small nonprofits. I just want you to be aware of that.

Thank you.

Secretary PEREZ. Thank you, sir.

NPRM FOR DRUG SCREENING OF UI CLAIMANTS

Mr. COLE. Okay, Mr. Secretary, on February 22, 2012, President Obama signed Public Law 112–96. It is the Middle Class Tax Relief and Job Creation Act of 2012. It is bipartisan legislation authorizing drug screening and testing of unemployment insurance claimants in very limited cases.

Nearly 20 months after the President signed the law, the Department of Law issued the Notice of Proposed Rulemaking, NPRM, pertaining to this provision. It is my understanding that the NPRM falls significantly short of achieving the intended purpose of the statutory provision.

It places significant limitations on when drug screening and testing can occur, all but ensuring that the law will not be implemented as intended. I know that members of the Ways and Means Committee have repeatedly raised similar concerns regarding the NPRM and have received, in their view, limited communications from the department. Could you tell us what your plan is for actually finalizing the rule, and will the final rule address the concerns and recommendations raised by other Members of Congress submitted formally through the public comment period?

Secretary PEREZ. We certainly take seriously our obligation to uphold the integrity of the UI program. We got a lot of feedback, and it was all very constructive feedback. We did a lot of review, and the final rule, the proposed final rule was sent over to OMB yesterday.

So that process now begins over at OMB because I remember—I had a whole list of things that I knew that we needed to get done. This was a mandate that Congress gave us, and we take that responsibility very seriously. So it went over, I think, yesterday, if my memory serves me. But it is over at OMB.

Mr. COLE. Did the hearing have any force in triggering—

Secretary PEREZ. Oh, come on, Mr. Chairman.

[Laughter.]

Secretary PEREZ. The overtime rule went over yesterday as well. So—

Mr. COLE. Yes.

Secretary PEREZ [continuing]. You know, one could argue that maybe one should wait until the end of a hearing to send that over, but that is not what we do. When we are ready to send something over—

Mr. COLE. No, no, I just—

Secretary PEREZ [continuing]. We send them over.

Mr. COLE. Deadlines sometimes are helpful.

Secretary PEREZ. There is nothing like a deadline to focus the mind.

Mr. COLE. Yes, we are not going to have too much time left. So I am going to stop my questioning at that point to make sure that every Member has an opportunity to get at least one more question in, if we may?

Secretary PEREZ. Okay. Great.

Mr. COLE. With that, I will go to the gentlelady from Connecticut.

Secretary PEREZ. Thank you, sir.

ENDING LONG-TERM UNEMPLOYMENT

Ms. DELAURO. Thank you very much, Mr. Chairman.

A quick question, if I might, on long-term unemployment. We talked about expanding reemployment services for UI. I just wanted to bring to your attention, I think you know about it, the Platform to Employment Program, the P2E program that Connecticut has undertaken and, I might add, quite successfully.

Nearly 80 percent of Connecticut participants who complete the preparatory program take the next step into a work experience at a local company. Of this population, nearly 90 percent have moved to employer payrolls.

How does your budget deal with leveraging these public-private partnerships to help a P2E program succeed?

Secretary PEREZ. Sure. When you look at the success, whether it is Oklahoma, Maryland, or Connecticut in the workforce space, it is a joint venture of Federal, State, and local governments and the private sector, educators, nonprofits, faith communities, tribes and others. This is no different.

The work we have made and the progress we have made on long-term unemployed has been a function of the fact that there has been remarkable innovation. We know—we have a much better idea today of what works than we did 5 years ago, and let me give you one quick example.

There is a tool in our toolbox in the workforce system. We call it on-the-job training. What it really is, is we will subsidize your wage for a certain period of time. So an employer looks at a worker who has got an 18-month gap on her resume. Katherine Hackett from Connecticut—

Ms. DELAURO. Right.

Secretary PEREZ [continuing]. Is an example. Remarkably talented, but you know, but for the grace of God could have been any of us who lost their job. This employer looked at her and said, you know, she has like 70 percent of what I need. Then we give them that final push. So we subsidize the wage for a certain period of time, and then at the end, it is the employer's choice whether they keep them or not.

We have an over 90 percent success rate with this program, and we have targeted it in many communities to the long-term unemployed, and it has been tremendously successful across different sectors. So unemployed engineers who are in their fifties and confronting a number of barriers, but with remarkable talent.

So we have learned so much. You know, a crisis does create opportunities to learn and then move forward.

DOL WORKER PROTECTION AGENCIES

Ms. DELAURO. Let me ask about worker protection agencies at the department. OSHA and MSHA protect workers from health and safety hazards. Wage and Hour makes sure workers aren't cheated out of their wages. OFCCP enforces rules for Federal contractors against discrimination on race, sex, religion, disability. EBSA ensures retirement savings and health benefits are secure.

These programs, Mr. Secretary, were flat funded last year, despite the \$66,000,000,000 increase in defense and nondefense. It is not just the refusal to fund the initiatives. Agencies rely on personnel. Flat funding means absorbing small pay raises, annual increases in healthcare costs by reducing staff levels, or foregoing necessary procurements. You can't do more with less. You can only do less with less.

So I won't go into the numbers here, but you have got OSHA built-in cost last year, \$17,000,000. MSHA, \$9,000,000. Wage and Hour, \$6,000,000. OFCCP, about \$5,000,000. Total \$40,000,000, and yet the cumulative increase for these five agencies last year was negative \$1,000,000.

How does the funding freeze affect your agencies, and how it is affecting the ability to protect low-income workers?

Secretary PEREZ. Well, it affects safety. I mean, OSHA, in the best of days, I think would take over 100 years to visit every employer in America. So we have got to be strategic about it. When we have less resources, we have more potential for danger, and that not only hurts workers, but it hurts employers who play by the rules.

Because if you have a speed limit sign that says "speed limit 40 miles an hour," but underneath it, it says "self-enforcement," you are going to end up with a lot of speeders and a lot of accidents. That is why we have done our level best to partner with States, and we do so on misclassification with States—Utah, Texas, Massachusetts. We are doing partnerships with local governments.

But the reality is it hurts, and we know that there are low-wage workers who are getting abused, and we do our level best to help, but there is only so much help we can do. There are only so many hours in a day.

Ms. DELAUR. Thank you.

DOL REGULATORY SCHEDULE

I just want to get final assurance to the subcommittee that the administration is finalizing several of these long-awaited rules that protect worker safety and ensure that workers keep their hard-earned money. I would like to know if we will see finalized rules in the near future for the following three regulations—silica, fiduciary rule, and you mentioned overtime pay, which was you said went to OMB yesterday.

Secretary PEREZ. Thank you.

Ms. DELAUR. Final, are we—

Secretary PEREZ. Oh, yes. We are moving forward—

Ms. DELAUR. The fiduciary rule?

Secretary PEREZ. The conflict of interest rule was sent to OMB.

Ms. DELAUR. It went to OMB?

Secretary PEREZ. Over a month ago. Overtime was sent yesterday. The UI one was sent yesterday.

Ms. DELAUR. Silica?

Secretary PEREZ. Silica was sent in December, I believe.

Ms. DELAUR. Okay.

Secretary PEREZ. They are all under review at OMB. Then there was an NPRM on the regulation to implement the executive order on paid leave—

Ms. DELAUR. Paid leave.

Secretary PEREZ [continuing]. That went over to OMB I want to say 2, 3 weeks ago.

Ms. DELAUR. Okay. Mr. Secretary, many thanks.

Mr. COLE. Mr. Secretary, I am glad you know that you drive the GW Parkway on a regular basis as well. So—

[Laughter.]

Mr. COLE [continuing]. With that, I go to my good friend Mr. Harris for what is probably the last question of the hearing.

OSHA RULEMAKING

Mr. HARRIS. Thank you very much.

Just to follow up on the gentleman from Pennsylvania with regards to the retail facilities language in the omnibus, you know, it

also had other directives—for OSHA to establish new classification code for retailers, carry out all notice and comment rulemaking procedures, which I would—I don't know if that is—you know, maybe in a QFR, you will—you can respond as to where that stands.

The other thing, just from a chemical point of view, you bring up west Texas. But you know, all ammonia—I am sorry, ammonia and ammonium is not the same. You know, it is anhydrous ammonia in west Texas, highly dangerous. And yet the new retail rule is going to deal with the sale of ammonium nitrate, which is a fertilizer, which again is my concern because of a rural area.

But let me just follow up with the silica, a question about the silica. And this should be a pretty straightforward one, I think—I hope—for you to answer is that the new silica rule is going to set up where the employers have 180 days to test for exposure and to determine how they are going to comply with the rule. And obviously, that new rule is going to result in thousands and hundreds of thousands of samples having to be sent to reference labs to determine silica levels.

But OSHA is going to give the labs 2 years to be in compliance with the lab improvement requirement. So you have got the labs, which have 2 years to kind of demonstrate that they can actually do this, and yet the employers have only 180 days to actually do this and implement the changes.

So if an employer—if a lab does not—is not OSHA certified its compliance with the lab improvement requirements, is OSHA still going to use those lab results from the noncertified compliant lab in order to enforce employer regulations? I mean, if you get the disconnect?

I mean, employers have 180 days, but they are going to use labs that may not be compliant for 2 years.

Secretary PEREZ. Well, you are referring to issues that were in the NPRM, the proposed rule. We had a very lengthy process, and now we are—we have been in the process of reviewing all the rules and issuing a final rule. So I can't comment on the specifics. But what I can say is when we publish a final rule, we will be happy to explain how we resolved that and any other issue that you might have.

Mr. HARRIS. See, I knew you could hit that one out of the ballpark.

Thank you very much, Mr. Secretary. [Laughter.]

Mr. COLE. The gentlelady from Connecticut asked for an additional question. So she is recognized to pose it.

Ms. DELAURO. It really isn't an additional question, but I just wanted to say with regard to silica, which has a devastating effect on workers' health, as we know—classified as a carcinogen—Department of Labor has been trying to address the dangers for 80 years. In 1937, Secretary of Labor Frances Perkins announced the findings of a report linking silicosis to workplace exposure.

1938, Frances Perkins held a national silicosis conference and initiated a campaign to "stop silicosis," stating, and I quote, "Our job is one of applying techniques and principles to every known silica dust hazard in American industry. We know the methods of control. Let us put them into practice."

Mr. Secretary, thank you, thank you, thank you for this effort and helping to make a difference in the health and safety of American workers.

Secretary PEREZ. We have the grainy video of—

Ms. DELAUBRO. I want it.

Secretary PEREZ [continuing]. Frances Perkins, by the way. She wears hip hats, just like Congresswoman DeLauro. [Laughter.]

Secretary PEREZ. I don't know if she was called a hipster back then, but—

CLOSING STATEMENTS

Mr. COLE. Mr. Secretary, this won't be our last opportunity to work with you, but it is probably your last appearance before this committee in a formal setting. So I just want to take the opportunity to publicly thank you. You have always been responsive to our questions.

And even when we have disagreed on issues, you have always been agreeable and professional in arguing your case and the administration's case. And I just appreciate the years of public service, both before you arrived here and in this capacity and look forward to working with you for the remainder of your tenure.

Secretary PEREZ. Me, too. It is a privilege to be with you. In a town where all too frequently, we lose sight of things like civility, you are a remarkable example of how to get things done and get things done in a manner that is respectful and really moves the ball forward. So it is always a privilege.

Mr. COLE. You are very kind. So we are now adding a trip to Oklahoma to your travel. [Laughter.]

Mr. COLE. With that, we are adjourned.

[The following questions were submitted to be answered for the record:]

Questions for the Record from Mr. Cole

WIOA IMPLEMENTATION

Mr. Cole: When does the Department anticipate issuing final regulations related to the implementation of the Workforce Innovation and Opportunity Act?

Mr. Perez: The Departments of Labor and Education continue to work aggressively toward making the final regulations publicly available in June 2016. The Departments collectively published five Notices of Proposed Rule-Making (NPRMs) on April 16, 2015 and the final rules are now under review at the Office of Management and Budget. Consistent with WIOA's spirit of alignment and coordination, the Departments jointly proposed regulations consisting of state planning, one-stop system, and performance accountability provisions, in addition to DOL-only and ED-only regulations. Working together with additional federal partners, the Departments also proposed aligned data and reporting packages for state planning and performance reporting. As a result of these publications, the Departments received extensive public comments, all of which are being considered in the development of final WIOA regulations and reporting packages.

Mr. Cole: Please update the table provided in fiscal year 2015 to reflect the actual use of fiscal year 2014-16 funds for technical assistance and other activities related to the implementation of WIOA. Please also include on the table all funds requested in the fiscal year 2017 budget for technical assistance and other WIOA implementation activities.

Activity	FY/PY 2014	FY/PY 2015	FY/PY 2016
WIOA Implementation & IT	4,685,796	1,000,000	12,486,000
Technical Assistance	2,850,000		3,232,000
Grants to States & Others	11,500,000		
Total	19,035,796	1,000,000	15,718,000

Mr. Perez: This table shows the information requested:

Dislocated Worker (DW) Technical Assistance and Training (TAT) Funds Spent on WIOA Technical Assistance and Implementation Activities				
Activity	PY 2014 DWTAT Obligated	PY 2015 DWTAT Obligated	PY 2016* DWTAT and WIOA TA Appropriated but Not Obligated	PY 2017** Requested

WIOA Implementation & IT	\$0	\$8,200,000	Up to \$11,100,000	Up to \$11,100,000
Technical Assistance	\$0	\$3,215,900	At least \$3,232,000	At least \$3,232,000
Grants to States & Others	\$10,856,352	\$0	TBD	TBD
Total	\$10,856,352	\$11,415,900	Estimated \$14,332,000	Estimated \$14,332,000

Other Funds Spent on WIOA Implementation Activities

Activity	PY 2014 WDQI Obligated	PY 2015 WDQI Obligated	PY 2016*** WDQI Appropriated but Not Obligated	PY 2017 WDQI Requested
	FY 2014	FY 2015	FY 2016 Spending to Date	FY 2017 Requested
WDQI	\$6,000,000	\$4,000,000	\$6,000,000	\$40,000,000
Program Administration	\$3,235,796	\$3,787,588	\$265,000	\$11,226,000
ES TAT	\$0	\$80,000	\$750,000	\$0

*The FY 2016 funds for PY 2016 become available in July and October of 2016. We are planning to prioritize these funds for several key IT projects, technical training for the WIOA regulations, and technical assistance to implement strategies for success. For PY 2016, technical assistance funds will include the additional 5 percent of Dislocated Worker TAT funds authorized for WIOA implementation, and technical assistance as needed, as well as the \$3,232,000 authorized for the first time in the FY 2016 Consolidated Appropriations Act for technical assistance activities under Section 168 of WIOA.

**In FY 2017, the Department requested \$3,232,000 for WIOA TA and continued flexibility within the appropriations language to expand the allowable use of the National Reserve technical assistance and training funds (DW TAT) to include activities that support WIOA implementation. These funds are also available on a Program Year basis and will become available in July 2017.

***The PY 2016 funds are appropriated in FY 2016 and do not become available until July 2016.

- As you are aware, the FY 2015 appropriation provided an additional 5 percent of the Dislocated Worker National Reserve above the historic 5 percent for technical assistance to be available in PY 2015, and retroactively in PY 2014, to support WIOA technical assistance, transition, and implementation activities.
- During PY 2015, we received approximately \$22 million for Dislocated Worker (DW) Technical Assistance and Training (TAT) activities (inclusive of both traditional TA and WIOA technical assistance and transition and implementation activities). ETA spent approximately \$11 million of that funding on our traditional activities which are funded annually. The additional \$11 million (appropriated through the additional 5 percent for WIOA transition activities) is being used for implementation and IT systems, technical assistance, and grants to states for implementation.

- In PY 2016, ETA plans to spend approximately \$14.3 million on WIOA Implementation activities, which includes both technical assistance and IT. Of the \$14.2 million, \$11.1 million will be funded with the additional 5 percent of Dislocated Worker TAT funds, and \$3,232,000 will be funded with the newly authorized Section 168 of WIOA technical assistance activities funds. As you know, this line item was appropriated in the FY 2016 Consolidated Appropriations Act for the first time. These appropriated funds will become available for DOL obligation in two stages, on July 1, 2016 and October 1, 2016.
- The Department is leveraging the Workforce Data Quality Initiative (WDQI) funds in PY 2014, PY 2015, and PY 2016; and the Department requested increased funding for WDQI in PY 2017. These grants help states connect data infrastructure across education and training programs, which can be used to support their efforts to meet the performance accountability requirements under WIOA.
- The Department proposes to expand WDQI into the Workforce Data System Integration (WDSI) initiative to further the focus on high quality data to better understand how workforce and education programs affect the labor market and workforce outcomes of the job seekers. In the FY 2017 Congressional Budget Justification, the Department requested \$40 million for PY 2017; of the total funding, \$33 million will help states build integrated or bridged data systems to facilitate WIOA implementation.
- The 2017 Budget also requests \$500 million over five years for the WIOA Workforce Data Science and Innovation Fund to operate on a PY basis. This initiative, distinct from WDQI, focuses on reducing the costs, and increasing the quality, of integrated state labor data systems through foundational investments to develop open source data analytics tools, standard data exchange formats, and scalable, open-source database architectures.
- Additionally, the Department used FY 2014 and FY 2015 Program Administration (PA) funds to fund a range of activities that support technical assistance to states and other stakeholders, including: the WIOA 101 webcast series, quick-start action planners; the Innovation and Opportunity Network (an electronic learning exchange); a national convening; peer learning groups; customer-centered design training; internal staff training and other technical assistance. Additional PA funds underwrote logistical support for the preparation and publication of regulations and information collections. This support is in addition to the support PA funded FTE are providing for implementation.
- Further, with FY 2015 and FY 2016 Employment Service Technical Assistance and Training (ES TAT) funds, ETA supported a cooperative grant agreement with the National Association of State Workforce Agencies for technical assistance, outreach and communications with stakeholders, and technical assistance on training strategies and business services. ES TAT funds operate on a fiscal year basis.

Mr. Cole: Please describe the purposes and types of activities being undertaken with technical assistance funds for WIOA implementation.

Mr. Perez: As you are aware, the FY 2015 appropriation provided an additional 5 percent above the historic 5 percent for technical assistance to be available in Program Year (PY) 2015, and retroactively in PY 2014, to support WIOA technical assistance and transition activities. A little over \$2 million became available in July 2015 (PY 2015 base funds) with the remaining \$20 million was available in October 2015 (PY 2015 Advance funds). During PY 2015, we obligated approximately \$11 million to our traditional Dislocated Worker (DW) Technical Assistance and Training (TAT) activities, which are funded annually. The additional 5 percent for WIOA transition activities (roughly \$11 million) is being used for investments for key Federal IT infrastructure updates and WIOA Technical Assistance (TA), including grants to states for implementation. The key Federal IT infrastructure updates include gathering requirements for and building the robust performance reporting system envisioned by WIOA and necessary for all WIOA grantees to report common performance measures. Additionally, the Department significantly increased its financial support of the Wage Record Interchange System to allow for expansion of wage record access necessary for WIOA performance reporting, and the technical and legal work among states necessary to achieve that expansion. We have obligated most of the PY 2015 DW TAT funds and any remaining funds are in the process of being obligated by September 2016.

The WIOA TA activities (as defined by the Technical Assistance line in the chart above) included expert coaching, guides, assessments, toolkits, webinars, peer-to-peer discussions, and peer-to-peer coaching for states and locals. For example, the Department launched a WIOA resource page on July 21, 2014, to provide state and local leaders, practitioners, and stakeholders with information resources and technical assistance materials. This page had recorded 517,174 total views through March 2016. We also have hosted 28 WIOA technical assistance webinars; shared numerous assessment tools to help leaders at all levels of the public workforce system plan for WIOA implementation; and distributed podcasts and videos describing workforce system best practices and replicable models.

The January 2016 National Convening on WIOA Implementation, attended by teams from 49 states, was co-hosted by the Department with Federal partners and stakeholders. An estimated 850 state holders were in attendance. TA topics focused on training program staff, designing improved American Job Center systems, enhancing assessments and access to labor market information, and developing other tools/resources. Priority areas were identified through workforce system stakeholder input and the analysis of the complexities of implementing certain provisions, and include:

- Conducting robust strategic planning across the core programs and additional partners at the state, regional, and local levels. This includes

positioning state and local workforce development boards as strategic leaders.

- Implementing customer-centered, integrated American Job Center services so that job seekers and employers have access to high-quality workforce services that enable both to prosper. This includes successfully negotiating infrastructure/shared services costs, addressing real estate issues generated by co-location requirements, and developing training models to cross train front-line center staff.
- Implementing evidence-based strategies, including work-based training models, such as Registered Apprenticeship and OJT; services to out-of-school youth to prepare them for in-demand occupations; and use of sector strategies and career pathways.
- Implementing effective and robust business engagement strategies.
- Using integrated reporting systems to inform customer choice and support data-driven performance and program management. This includes supporting the integration of intake, case management, and performance reporting systems, as well as fiscal and management accountability systems.

These activities will be provided at three levels:

- Universal capacity building activities designed to increase broad awareness and understanding across the workforce system;
- Targeted capacity building activities to reach specific cohorts (e.g., state and regional leaders, local workforce development board members, and American Job Center staff) to increase their competencies and skills; and
- Customized activities to build the capacity of organizations and systems to implement WIOA.

Looking ahead, when the PY 2016 funds become available in July and October of this year, we are planning to prioritize using them for key IT projects; primarily developing and maintaining the new performance reporting system for WIOA grantees, technical training for the WIOA regulations, and technical assistance to implement strategies for success. Successfully establishing the performance reporting system is a cornerstone of this implementation, and will result in increased accountability and information for job seekers and the public through aligned and new performance indicators that show data on training providers' performance outcomes.

PY 2017 WIOA Implementation technical assistance will build upon efforts provided through similar funds received in PY 2016. The Department will assess the first two years of WIOA implementation in order to determine the priority areas for technical assistance in PY 2017. Technical assistance will continue to include a strong focus on strategic planning, resource and programmatic alignment, and accountability and transparency. Activities will focus on training staff, designing improved American Job Center systems, enhancing assessments

and access to labor market information, and developing other tools/resources in priority areas identified through workforce system stakeholder input and the analysis of the complexities of implementing certain provisions.

WIOA requires that the Department maintain the capacity to provide training and technical assistance to the workforce system and its staff, in particular to replicate effective practices; train state and local boards; integrate intake, case management, and financial management systems and program operations; and transition to the new law. In addition, WIOA requires the Department, along with the Department of Education, as needed, to provide technical assistance to grantees that fail to meet the adjusted level of performance for a primary indicator of performance.

JOB CORPS ENROLLMENT

Mr. Cole: Please provide a table showing the enrollment data for the Job Corps program for the funds appropriated in fiscal years 2014-15 and projected enrollment for fiscal year 2016. Please also include projected enrollment in fiscal year 2017 if funding requested in the budget is enacted.

Mr. Perez:

	PY 2014 Result	PY 2015 Target	PY 2016 Target	PY 2017 Target
New Enrollments	52,415	49,601	49,601	49,601

Job Corps is an open enrollment, open exit program and as such new students enter the program on a weekly basis and they progress at their own pace. The new enrollments number shows the number (or estimated number) of new students who enter the program during the 12 month Program Year (PY).

The 2017 Budget continues the Administration's commitment to strengthening the Job Corps program and improving student outcomes by taking the necessary actions to support the Department's strategic goals and objectives. In PY 2017, Job Corps will be completing its implementation of WIOA. Additionally, Job Corps will be in its third year of implementation of a streamlined and modernized program design that incorporates the program reforms directed by WIOA; improvements based on best practices of high performing centers; and an updated academic and technical training design developed in partnership with industry representatives and educational organizations.

The requested increase will be used for Job Corps initiatives such as upgrading safety and security of Job Corps for students and staff, including updating physical security measures on center; increasing center staff and training to engage students in after-hours learning; increasing mental health personnel and developing an integrated behavior management system; continue implementing

demonstration projects to test a range of novel approaches to achieve improved results for students; and modernizing curricula, upgrading equipment, and refining training to provide skills that are in high demand.

JOB CORPS CENTER CLOSURES

Mr. Cole: Please explain the Department's rationale for proposing to close the Ouachita Job Corps Center.

Mr. Perez: The Job Corps program provides economically disadvantaged youth the academic, career technical training, and employability skills to enter the workforce, enroll in post-secondary education, or enlist in the military. The Department is committed to improving the performance of Job Corps centers and ensuring that Job Corps' resources are used to efficiently and effectively deliver the best possible results for the students we serve.

On March 9, 2016, the Department published a *Federal Register* notice (81 Fed. Reg. 12529) soliciting comments on a proposal to close the Ouachita Job Corps Center and identified three criteria for determining when a Job Corps center should be closed:

- Closure based on chronic low-performance, as announced in an August 2014 *Federal Register* notice (79 Fed. Reg. 51198) but updated to use the most recent five years of performance data available;
- Closure based on a joint decision of the Secretaries of Labor and Agriculture, described in a December 2014 report to Congress; and
- Closure based on an evaluation of the effort required to provide and maintain a high-quality, safe and productive living and learning environment at a center and whether that effort is likely to ultimately produce an outcome that contributes to the program's overall strength and integrity.

In determining to propose a center for closure based on one or more of the criteria described above, the Department then applies the following additional considerations, as appropriate: continued availability of services in all 50 states, Washington, D.C., and Puerto Rico; availability of five full years of performance data for a center; evidence of significant recent performance improvement; and the effect on Job Corps' continuing commitment to diversity.

The Department has proposed to close the Ouachita Job Corps Center based on its chronic low-performance. As described in the *Federal Register* notice, the low-performance criterion utilizes the following performance-based criteria to determine a center's Overall Rating: five-year Outcome-Measurement System (OMS) performance level (the OMS is a collection of metrics used to assess a center's quantitative performance outcomes); five-year On-Board Strength (OBS); and five-year Facility Condition Index (FCI), with the recent years

weighted more heavily. In applying these criteria, Ouachita received the lowest ranking of all Job Corps centers across the nation. Ouachita performed substantially below Job Corps national averages in terms of student completion of career technical training, achievement of high school diplomas/general education development certificates, job placement, and center safety over a five-year period (PY 2010 to PY 2014). After ranking the centers based on the primary criteria, the Department then applied the additional considerations but determined that none precluded the closure of Ouachita. After consideration of all of the comments received on the proposal, should the Department ultimately decide to close the Ouachita Job Corps Center, it would transition existing students to other higher-performing Job Corps centers, including other centers in the state and in the region.

Prior to proposing the Ouachita center for closure, the Department and the U.S. Department of Agriculture (USDA) developed a joint Performance Improvement Plan (PIP), a detailed and measurable plan to with specific targets and completion deadlines, to improve the center's performance in PY 2011. Despite a four-year long effort, Ouachita only made minor progress and failed to meet specified targets needed to graduate from the PIP, among them: a ranking greater than the bottom quartile, and a staff vacancy rate of 5% or less. Furthermore, in PY 2014, the Department established a performance improvement team of high-level Job Corps and USDA staff to assist Ouachita to achieve targets set forth in the PIP. Despite additional assistance, Ouachita remained within the bottom quartile of the Outcome Measurement System with a rank of 122th out of 126 centers as of December 2015.

As part of its ongoing management efforts to improve the Job Corps program and achieve better outcomes for students throughout the system, the Department may determine that closing a chronically low-performing center will improve Job Corps' ability to provide the highest-quality education and career technical training to its students, system-wide. It is the Department's responsibility to work to provide Job Corps centers that produce the best possible results for students with the limited resources available to the overall program. The Department does not deem it prudent to continue to invest its resources in centers that have consistently and repeatedly failed to serve students well.

Mr. Cole: In February 2015, a report on estimated costs and savings related to the closure of the Treasure Lake Job Corps Center was provided to the Appropriations Committees. Please provide any updates to the actual costs incurred through March 31, 2016 or to the cost estimates that were provided in the February 2015 report.

Mr. Perez: As noted in the Department's FY 2015 Operating Plan Addendum, the Department and the U.S. Department of Agriculture (USDA) estimated that the closure of the Treasure Lake center could cost \$4,000,000, with the potential

for costs to go higher. The actual costs realized to date are approximately \$2,000,000.

COMPETING LOW PERFORMING JOB CORPS CENTERS

The Department does not propose to retain General Provision Section 109 from the fiscal year 2016 Appropriations Act. Section 109 gives the Department the authority to compete low performing Civilian Conservation Centers.

Mr. Cole: Is the assumption in the budget that the Department will not compete any such centers in fiscal year 2017 or that the Department may carry out the competition under the authority provided in WIOA and that Sec. 109 is not necessary for that purpose in fiscal year 2017?

Mr. Perez: The Department has not made a determination on whether to compete any Civilian Conservation Centers (CCCs) in Fiscal Year (FY) 2017. As originally proposed, General Provision Section 109 of the FY 2016 Appropriations Act would have applied to all future years and would not have needed to be repeated in the FY 2017 appropriations provisions. However, as enacted, the Department's 2016 appropriation did not include this future application language. Accordingly, the Department recommends that the FY 2017 appropriations bill contain the following updated language, which would obviate the need for subsequent annual reauthorizations to enable the Department to compete low performing CCCs:

SEC. 109. Notwithstanding any other provision of law, beginning October 1, 2016, and thereafter, the Secretary of Labor, in consultation with the Secretary of Agriculture, may select an entity to operate a Civilian Conservation Center on a competitive basis in accordance with Section 147 of the WIOA, if the Secretary of Labor determines such center has had consistently low performance under the performance accountability system in effect for the Job Corps program prior to July 1, 2016, or with respect to expected levels of performance established under Section 159(c) of such Act beginning July 1, 2016.

JOB CORPS FINANCIAL MANAGEMENT

Mr. Cole: Please provide an update on the Department's efforts to improve financial management of the Job Corps program including any ongoing work with DOL-OIG to implement audit recommendations from prior years and other efforts to strengthen financial control systems.

Mr. Perez: Implementing financial and management improvements in the Job Corps program has been a priority for the Administration. The Employment and Training Administration (ETA), which oversees Job Corps, has spent nearly four years working diligently to strengthen contract oversight and financial management in accordance with the recommendations made by the Department's

Office of Inspector General (OIG) in its report on the financial problems in Program Years 2011 and 2012. We have also ensured that all necessary DOL agencies, both within and outside of ETA, are actively participating in this effort. For example, Job Corps and the Chief Financial Officer have established mechanisms for detecting potential financial and program risks such as over obligation of appropriations and expenses in excess of contracted budgets. Contract obligations and expenses are reviewed and reported monthly to stakeholders. Tri-office meetings with Job Corps, Contracts Management and the Office of Financial administration are conducted bi-weekly with the regional offices; weekly at the national level.

As a result, on March 24, 2015, the OIG determined that Job Corps had taken appropriate corrective action and that all of the recommendations from its financial management audit are closed. The Department remains committed to ensuring that contract values and Job Corps program commitments remain within the amount appropriated by Congress. ETA continues to monitor contractor expenditures to ensure that they are allowable, allocable, and reasonable, as required by the Federal Acquisition Regulation. This monitoring includes assessing whether the incurred costs are consistent and appropriate with the terms of the contract, such as the number of students served at the particular center.

The Department is committed to ensuring that the Job Corps program remains in sound financial health so that we can continue to serve our students well now and into the future.

RATE OF OVERPAYMENT IN THE UI PROGRAM

Mr. Cole: Please provide an update on the Department's efforts to improve the rate of overpayment recoveries in the Unemployment Insurance program including the use of additional funds appropriated in fiscal year 2016 for reemployment services and State IT infrastructure.

Mr. Perez: All state laws provide for recovery of Unemployment Insurance (UI) benefit overpayments. Each state identifies UI improper payments, which also translate into overpayments for recovery, through methods such as cross-matching claimant Social Security Numbers with State and National Directories of New Hires (NDNH); wage record files submitted quarterly by employers; matches with other public and private databases, such as incarceration data; and through other sources, such as appeals reversals, and tips and leads.

States must follow their individual state laws and policies in executing recovery efforts. In addition to direct repayment by claimants, overpayment recovery efforts by states include future benefit payment offsets, state income tax refund offsets, Federal income tax refund offsets via the Treasury Offset Program (TOP), wage garnishments, interception of lottery winnings, and pursuing both civil and criminal action in state courts. From FY 2008 through FY 2015,

approximately \$9.42 billion was recovered for the UI program (including the State UI, UCFE, UCX, EB, and EUC programs).

The Department has been working for several years to accelerate state actions to prevent, detect, and recover improper payments. To support states' efforts, the Department provided over \$350 million in supplemental funding opportunities and incentives each year from FY 2011 through FY 2015 that supported the Department's UI integrity strategic plan. This funding has led to widespread state adoption of strategies such as the use of the NDNH for cross-matching UI claims, TOP for the recovery of fraud and certain non-fraud overpayments, and the State Information Data Exchange System (SIDES) for timely and accurate exchange of employer information.

As of March 2016, a total of 44 states have implemented TOP and 6 additional states are in various stages of TOP implementation. An estimated \$221.6 million in UI overpayments were recovered through TOP in FY 2015, and a total of \$1.67 billion in overpayments were recovered since the program's inception.

In its Fiscal Year 2015 Agency Financial Report, the Department reported an estimated improper payment rate of 10.73 percent for the 12-month period ending June 2015, a decrease of 0.84 percentage points from the estimated 2014 improper payment rate of 11.57 percent.

In FY 2016, as in prior years, the Department will offer states the opportunity to apply for supplemental funding to support program integrity strategies, including recovery of overpayments and automation projects to support program integrity using unearned above base funding to the extent it is available.

STATUS OF VISA APPLICATIONS

Mr. Cole: Please provide a table showing the status of all PERM, H-2B and H-2A applications at the Department as of March 31, 2016. The table should include the number of applications received, the number of applications processed, and the number of pending applications for each of the programs compared with March 31, 2015.

Mr. Perez: Listed below are the workload table summaries requested for the specified time period showing the status of all PERM, H-2B and H-2A applications at the Department as of March 31, 2016. "Applications Carried In" refers to applications active and pending review at the beginning of the time period reflected in the charts below.

PERM Workload Summary

Workload Category	FY 2015 Oct 1 - Mar 31	FY 2016 Oct 1 - Mar 31	% Difference FY 16 v FY 15
-------------------	---------------------------	---------------------------	-------------------------------

<i>Applications Carried In (Oct 1)</i>	54,523	54,558	0.0%
<i>Applications Received</i>	42,189	46,519	10.3%
Total Applications	96,712	101,077	4.2%
Determinations	40,932	61,556	50.4%
Applications Remaining ^{1/}	56,653	40,115	-29.2%

^{1/} Applications Remaining for PERM will not equal Total Applications minus Determinations as applications may be reconsidered during the appeals process.

H-2A Workload Summary

Workload Category	FY 2015 Oct 1 - Mar 31	FY 2016 Oct 1 - Mar 31	% Difference FY 16 v FY 15
<i>Applications Carried In (Oct 1)</i>	198	192	-3.0%
<i>Applications Received</i>	4,928	5,616	14.0%
Total Applications	5,126	5,808	13.3%
Determinations	4,436	4,811	8.5%
Applications Remaining	690	997	44.5%

H-2B Workload Summary

Workload Category	FY 2015 Oct 1 - Mar 31	FY 2016 Oct 1 - Mar 31	% Difference FY 16 v FY 15
<i>Applications Carried In (Oct 1)</i>	117	356	204.3%
<i>Applications Received</i>	5,667	6,036	6.5%
Total Applications	5,784	6,392	10.5%
Determinations	5,288	4,192	-20.7%
Applications Remaining	496	2,200	343.5%

Numerous external factors led to the H-2B backlog this winter. Riders in the FY16 Omnibus Appropriations Act necessitated the Department's pause in processing for two weeks in December and early January, during the heaviest application period of the year, to assess and deploy new procedures for the processing centers. At the same time, the improving economy resulted in an increase in the program's usage. DOL executed an intense push in February to clear the backlog of H-2B applications before the height of the summer hiring season. This push has resulted in reducing the overall applications remaining by 82 percent as of May 13, 2016 (from 3,658 on February 19th to 655 applications on May 13, 2016). The Department is now current on H-2B initial actions.

Because the H-2A filing season overlaps with the H-2B filing season, the resources available for processing both H-2B and H-2A applications were insufficient to meet the demand. Therefore, we also have been experiencing longer processing times for some H-2A applications. OFLC has also taken prompt action to try to restore normal processing times and reduce the number of pending

H-2A cases as quickly as possible. We are reallocating resources to hire seasonal contract staff and increased staff overtime hours, while attempting to maintain program integrity and minimize delays in processing. We have already reduced the number of pending H-2A applications by almost 57 percent between February 6 and April 30 (from 1,594 pending to 683 pending). Additionally, although the percentage of complete H-2A applications processed on time (i.e., no later than 30 days before the start date of need) dropped to 85 percent for the month of February 2016, we recovered quickly to 99.1 percent on time for the second week of May 2016.

Workload Categories:

- **Applications Carried In:** Total number of applications filed during the previous fiscal year, still pending a final determination, which are carried over into the current fiscal year.
- **Applications Received:** Total number of applications filed during the respective fiscal year.
- **Determinations:** Total number of applications adjudicated during the respective fiscal year.
- **Applications Remaining:** Applications still pending a final determination at the end of the respective fiscal year; these applications are carried over into the next fiscal year.

USE OF H-1B VISA FEES IN FY 2016

Mr. Cole: Please provide detail on the amounts from H-1B visa fees being used or expected to be used in fiscal year 2016 to reduce the backlog of PERM applications as authorized in Section 103 of the fiscal year 2016 Appropriations Act.

Mr. Perez: The Department of the Labor (Department) is utilizing the authority in Section 104 to significantly reduce the backlog of PERM applications in fiscal years 2016 and 2017. These resources will allow the Department to continue backlog-reduction initiatives started in FY 2015 and support new initiatives designed to keep backlogs from developing again.

In FY 2016, these funds are supporting approximately 17 federal and 44 contract staff to process PERM applications, as well as paying for the operation, maintenance, and improvement of the IT systems used to submit and adjudicate PERM applications. These improvements include enhancements and modifications that will support planned regulatory modernization of the PERM program. In total, the Department projects that during FY 2016 approximately \$7,000,000 of the \$13,000,000 authorized will be obligated. The Department will use the remaining funds to support backlog-reduction strategies in FY 2017. The Department expects to meet the backlog reduction targets outlined in Senate Report 114-74 by the end of FY 2017.

It is important to note that Section 104 is a one-time authority. While it will address the current PERM backlog, it will not address potential future backlogs resulting from the H-2B provisions in the FY 2016 Appropriations Act.

To improve the long-term speed and quality of certification processing, the Department continues to support the proposal in the President's FY 2017 Budget for legislation to move Foreign Labor Certification activities from an appropriation-based funding structure to a fee-based model. This would prevent application backlogs from developing in the future by creating a link between the demand for certifications and the resources used to process the applications.

Mr. Cole: What are the other activities the Department is funding or plans to fund with H-1B fees in fiscal year 2016?

Mr. Perez: In addition to the one-time authority in Section 104 of the fiscal year 2016 Appropriations Act outlined above, the Department annually receives 5 percent of the H-1B fees collected by the Department of Homeland Security (DHS). During FY 2015, the Department received \$17,594,898 through this funding mechanism. These resources also provide critical support for case processing activities in the H-1B and PERM programs. In FY 2016, these funds will pay for approximately 25 federal staff and 76 contractors involved in H-1B and PERM case-processing activities, as well as IT development and maintenance, rent, equipment, and overhead costs.

The Department also utilizes 50 percent of DHS H-1B collections to provide job training and related activities for workers to obtain or upgrade employment according to need in different sectors of the economy. Data collected by the Department about employers' applications for visas shows that employers continue to struggle to find workers in the U.S. that have the specialized skills needed for critical occupations in growing sectors, including information technology, engineering, education, and health care. Such domestic worker shortages threaten employer competitiveness, as employers lack the critical human capital needed to produce their goods and services.

In FY 2016, the Department initiated the following new grant programs in an ongoing effort to support the Department's goal to prepare American workers with skills and connect them to well-paying, middle- and high-skilled, and high-growth jobs in H-1B industries:

TechHire Partnership Grants

On November 17, 2015, the Administration announced the availability of \$100,000,000 in H-1B training funds to support innovative approaches to giving individuals the skills they need through innovative approaches that can rapidly train workers for and connect them to well-paying information technology and high growth jobs in industries, such as IT, healthcare, advanced manufacturing,

financial services, and other in-demand sectors. The Department anticipates awarding the TechHire Partnership grants in the summer of 2016, focusing on providing workers with the skills for a pathway to the middle class while providing employers with the skilled technology workers they need to grow and expand. These grants will serve people with barriers to accessing training and employment, both the unemployed and low-skilled front-line workers. At least \$50,000,000 will be awarded for projects serving youth and young adults who are out-of-secondary school, between the ages of 17 and 29 with barriers to training and employment opportunities. The remaining grant funds will be awarded to projects serving special populations defined as: individuals with disabilities, individuals with limited English proficiency, or individuals with criminal records with barriers to training and employment. Grants will pilot and scale public-private partnerships among the workforce investment system, education and training providers, and business-related nonprofit organizations in cities and states across the country. These partnerships will support the implementation of job-driven training strategies to help workers complete basic and technical skills training using evidence-based strategies such as accelerated learning, work-based learning and Registered Apprenticeships.

Strengthening Working Families Initiative

As a part of the Administration's efforts to support working families, the Department announced approximately \$25,000,000 in grant funds available for the Strengthening Working Families Initiative (SWFI) grant program on December 17, 2015. The grant program is designed to address education and training barriers for low- to middle-skilled parents by prioritizing the needs of this targeted population; addressing child care needs for parents seeking education and training; increasing access to child care resources; and bridging the gap between the workforce development and child care systems. The grants will support public-private partnerships that address systemic barriers and enable parents to access training and customized supportive services needed for IT, health care, and advanced manufacturing jobs, among others. All participants in grant funded projects must be custodial parents, legal guardians, foster parents, or others standing in loco parentis with at least one dependent. Up to 25 percent of the grantee's total budget may be used to provide quality, affordable care and other services to support their participation in training. These grant awards are scheduled to be announced in June 2016.

America's Promise Job-Driven Training Grants

The Administration will soon announce the availability of \$100,000,000 in America's Promise Job-Driven Training grants to strengthen the pipeline of skilled workers to expand an economic region's middle- to high-skilled workforce within one or more prioritized industry sector(s), thereby creating economic opportunities for America's workforce to gain the necessary skills to fill in-demand jobs and increasing the long-term competitiveness of an economic region.

To help achieve this goal, grantees will provide unemployed, underemployed, and low-income individuals the opportunity to get high-quality, tuition-free education and training that leads to in-demand and industry-recognized credentials and degrees. These grants would be awarded in early FY 2017.

WORKFORCE INFORMATION AND SYSTEMS BUILDING LINE ITEM AUTHORITY

Mr. Cole: Please describe why authority is requested under the Workforce Information and Systems Building line item for States to award subgrants to other States and to non-State entities? What non-State entities will be eligible to compete for funding?

Mr. Perez: The ability to award sub-grants to other States and to non-State entities provides flexibility in carrying out grant activities. For example, several groups of States have formed consortia to leverage resources to design, develop, and implement Information Technology (IT) systems, allowing them to pool their resources to develop IT solutions that they can all use. This approach satisfies the IT needs of all members of the group at a reduced cost as commonality in the systems can be shared. Typically, one State in a consortium has the lead for contracting and overseeing financial transactions and is provided the grant for the consortium. However, past experience has shown that responsibilities can change or it may be more efficient for a different member of the consortium to take on a portion of the contracting responsibilities. In such cases, moving grant funds that have been obligated to one State to another is cumbersome, and the sub-grant authority provides a more effective and efficient process to achieve that objective.

When a State has been awarded a grant for a particular activity and needs additional capacity or assistance to carry out the grant activities, a sub-grant to non-State entities may be the most efficient and least time consuming vehicle to achieve the objective. The Department is particularly interested in States being able to sub-grant to the Unemployment Insurance Information Technology Support Center and/or the Unemployment Insurance Integrity Center of Excellence, both operated by the National Association of State Workforce Agencies' Center for Employment Security Education and Research, for more intensive technical assistance support needed by States than is feasible using the core grants that support these entities. There also is an interest in these two entities being able to award sub-grants to States, either competitively or based on State interest and capacity, to pilot innovative strategies or to develop new tools that can benefit all States.

MULTIPLE EMPLOYER BENEFITS PILOTS

Mr. Cole: Why is funding for portable, multiple employer benefits pilots proposed as mandatory budget authority?

Mr. Perez: The FY17 Budget includes \$6,500,000 in discretionary funding for the Employee Benefits Security Administration (EBSA) to support a pilot program to implement new and different approaches to increasing retirement coverage in States, particularly for workers who are traditionally unable to access employment-based retirement benefits. This funding would be available through FY 2018 to allow sufficient time for EBSA to conduct a thorough process to solicit grant application and award grants, lessening the chance of lapsed funding. This process would consist of crafting a strong grant solicitation through an interagency process; providing technical briefings and outreach to potential grantees; allowing States time to develop effective grant proposals; and evaluating proposals and awarding grants. This grant funding would complement the Department's proposed regulation providing States a path forward to create their own retirement savings plans consistent with federal law.

But there is more that we can do at the federal level. Our system of retirement benefits has not kept pace with a rapidly evolving economy in which more individuals work as independent contractors and many frequently switch jobs. Approximately half of workers employed by firms with fewer than 50 workers and less than one-quarter of part-time workers have access to workplace retirement plans. To deal with the magnitude of the problem, the Budget includes legislative proposals to encourage new models that provide for more portability in retirement plans as well as access to retirement and other employer-provided benefits for self-employed workers and workers with multiple employers.

The Budget would remove barriers to the creation of open Multiple Employer Plans (open MEPs), which allow multiple unrelated employers to offer benefits through the same administrative structure but with lower costs and less compliance burden since the employers collectively operate a single ERISA-covered plan. The Administration seeks to eliminate the commonality requirement for retirement plans, while also adding significant new worker safeguards, thereby enabling more small businesses to offer cost-effective, pooled plans to their workers and facilitating pooled plans of self-employed individuals.

In addition, the Budget proposes \$100,000,000 of mandatory budget authority to finance pilots that design, implement, and evaluate new approaches to expanding retirement coverage and other employer benefits. Once authorized, DOL will administer the grant program through the Chief Evaluation Office, and grantees would be states or nonprofits. Under this legislative proposal, grantees will receive funding to pilot innovative, portable approaches to provide retirement and other employer-provided benefit coverage using the proposed open multiple employer plan structure or other existing structures. Priority will be placed on: (1) expanding coverage among the self-employed who are ineligible for many workplace retirement plans, individuals whose work patterns are intermittent and whose earnings are unpredictable from month to month, and employees who have multiple employers or who frequently switch jobs; and (2) developing models that

are portable across employers and that can accommodate pooled contributions from multiple employers to offer benefits for an individual worker.

CIVIL PENALTY ACTIONS AS A RESULT OF THE PENSION PROTECTION ACT

Mr. Cole: Please provide data on the number and type of civil penalty actions EBSA brought each year since enactment of the Pension Protection Act for failure to file an independent qualified public accountant (IQPA) report. The data should include the number of enforcement actions each year, the number and type of each penalty assessed, and the number of waivers granted each year by the Department for the Form 5500 filing requirement. With respect to monetary penalties for failure to file an IQPA report, please describe how the amount is determined. If there is a uniform penalty applied, please provide the amount(s) for the past five fiscal years (2011-15). If there is no uniform monetary penalty please provide the average penalty for each of the past five fiscal years.

Mr. Perez: The Department has authority to assess civil penalties of up to \$1,100/day on Plan Administrators who are required to file a Form 5500, but who fail to do so in a timely, accurate and complete manner.^[1] Unless an exception applies, the Department rejects filings that are missing a report of an Independent Qualified Public Accountant (IQPA report)^[2] and gives Plan Administrators 45 calendar days to correct their filings with no civil sanctions. Under EBSA policy, a failure to file a corrected report within this time frame is subject to a civil penalty of \$150/day (from the date the original filing was due) capped at \$50,000.^[3] Our enforcement policy and penalty structure with respect to missing IQPA reports has remained unchanged since 2006. There were no waivers granted for the requirement to attach the report of an independent qualified public accountant.

Plan Administrators have the opportunity to show reasonable cause for their reporting violations, as well as appeal the Department's penalty assessments with an Administrative Law Judge. Therefore, whether a penalty is assessed in full or abated in part or entirely depends upon the facts and circumstances of each case.

The table below presents penalty data from 2011 to March, 2016 solely for the failure to attach an acceptable IQPA report to Form 5500 filings. Abatements are not separately tracked.

Fiscal Year	Number of Penalties Assessed	Amount (\$)	Average (\$)
-------------	------------------------------	-------------	--------------

^[1] ERISA Section 502(c)(2)

^[2] Generally, funded plans with 100 or more participants at the beginning of the plan year are required to be audited and attach an IQPA report to their Form 5500 filings.

^[3] This penalty rate is not established by regulation but is instead the current policy of the Office of the Chief Accountant.

2011	400	10,779,976	26,950
2012	303	6,751,745	22,283
2013	111	3,236,727	29,160
2014	47	1,312,660	27,929
2015	63	1,699,271	26,973
2016 (March)	120	4,320,354	36,003

The table below presents penalty data from 2006 to 2010 for reporting compliance violations including, but not limited to, the failure to attach IQPA reports to Form 5500 filings. Penalties for specific violations were not broken out before 2011. Abatements are not separately tracked.

Fiscal Year	Number of Penalties Assessed	Amount (\$)
2006	325	10,614,619
2007	564	16,676,720
2008	260	6,829,598
2009	435	12,569,340
2010	361	9,572,421

DETAILS ON THE FY 2017 PBGC BUDGET REQUEST

Mr. Cole: Please provide a detailed breakout of the \$98.5 million request in the fiscal year 2017 budget over five years for the relocation of PBGC headquarters. Are all relocation and lease costs over the next five years included in this amount and if so, what is the proposed use of existing lease and related costs within the current administrative budget?

Mr. Perez: The Pension Benefit Guaranty Corporation (PBGC) is requesting funding for the consolidation of PBGC's three headquarter leases into a single headquarters replacement lease. Currently, PBGC has 471,247 square feet of leased space at: 1200 K Street, 1225 I Street and 1275 K Street. PBGC's headquarters leases expire in December 2018.

PBGC is currently working with the General Services Administration (GSA) to obtain a replacement lease which will maximize competition, reduce our federal footprint, and maximize workplace flexibility. PBGC will use the requested funding to plan, design, build and ultimately move. PBGC wants to ensure the best economic value, and has therefore consulted with experts within PBGC, GSA, other Federal agencies that have gone through a similar process, and the Office of Management and Budget (OMB) in order to ensure proper planning for this effort and to capture best practices and lessons learned. The lease will be executed using GSA Title 40 authority and will require House Transportation and Infrastructure and Senate Environment and Public Works authorization, as it is considered a prospectus lease.

The detailed breakdown of the \$98,500,000 costs are:

1. Real Property Costs - Potential Funding Requirement: \$40,700,000 (anticipated obligation beginning in 3rd quarter FY 2017)

In order to begin the competitive leasing process, PBGC needs to have funding for the real property costs. The real property funding estimate will cover items such as: Tenant Improvement (TI) construction, design, contingency and escalations (funding for construction cost increases), management fees (i.e., Lessor and/or GSA). The Real Property funding request takes into account a TI allowance and Lessor credits.

The following table shows the anticipated breakout of Real Property costs for planning purposes:

Real Property Cost (Design/Build) (\$ in millions)	
TI Construction	\$39.0
Design	\$2.0
Lessor's Mgmt Fee (8%)	\$3.1
Subtotal	\$44.1
10% Contingency	\$4.4
3% Escalations (3 years)	\$4.1
Subtotal (hard/soft costs)	\$52.6
Less: TI Allowance	(\$13.5)
Less: Lessor Credits/Capital	\$0.0
Net Real Property Cost	\$39.1
GSA 4% Mgmt Fee	\$1.6
Total Real Property Cost (Design/Build)	\$40.7

Availability of this funding will allow GSA to start the competitive leasing process.

2. Furniture, Fixtures and Equipment (FFE) - Potential Funding Requirement: \$47,800,000 (anticipated obligation beginning in 4th quarter FY 2018)

Once the lease is awarded, GSA will be able to enter into a lease agreement and begin the design, and initiate the build-out and move phases. The FFE costs cover items such as: IT infrastructure, cabling, mobility upgrades, security, data center migration, telecommunication system, security system for physical access controls, compliant with HSPD-12, meeting Interagency Security Committee (ISC) and Federal Protective Service (FPS) standards, wayfinding signage, furniture, program support, move related costs, contingency, escalations (funding for personal property cost increases), and GSA management fee.

The following table shows the anticipated breakout of Furniture, Fixtures, and Equipment costs for planning purposes:

Personal Property Cost (FFE) (\$ in millions)	
Move	\$4.0
IT, Telecom, AV, Cabling	\$13.0
Security (access card system)	\$2.5
Wayfinding signage	\$1.0
Furniture	\$9.0
Construction	\$1.0
IT Costs (Mobility Upgrades)	\$5.8
Program Support	\$2.5
Subtotal	\$38.8
10% Contingency	\$3.9
3% Escalations (3 years)	\$3.6
4% GSA Mgmt Fee	\$1.6
Total Personal Property Cost	\$47.8

This funding is needed once a building/location has been identified.

The relocation costs are covered in this FY 2017 budget request. However, the restoration costs for the three headquarters leases could possibly result in a potential new funding requirement. GSA and the Lessor would discuss restoration terms and negotiate any potential costs.

3. Lease Extension - Potential Funding Requirement: \$10,000,000
(anticipated obligation beginning in 1st or 2nd quarter FY 2019)

PBGC's budget request included \$10,000,000 for a short-term (1 year) lease extension at the current locations. The potential funding request was based upon rent escalations and GSA fees above the current baseline rent which would allow PBGC to remain at its current locations for another year.

From our benchmarking and based on input from GSA we found that there could be a number of potential delays (contract award, weather, construction and build-out, and union negotiations) in the overall lease project, which could potentially result in a delay of the build-out and or move phases and shift anticipated obligation dates. PBGC did not request additional resources within the \$98,500,000 if a longer extension is required. After the development of the FY 2017 budget, PBGC was notified by GSA that a longer-term bridge lease may be necessary. GSA would assist PBGC in negotiating a bridge lease. However, additional funding will be required if an extension goes into FY 2021 to cover the rent escalation beyond the budgeted one year extension and any termination cost,

if necessary. The bridge lease will be negotiated late spring or early summer and may extend in annual option year increments to FY 2023.

4. Baseline Administrative Budget - Includes all rent.

The baseline administrative budget for rent will continue to pay for the lease of the existing headquarters spaces and will be used for the lease costs for any new space in the future years.

CLAIMS PROCESSING TIME UNDER THE BLBA

Mr. Cole: Please provide data on the processing time for claims under the Black Lung Disability Trust Fund as of March 31, 2016 and compared to the same time last year. Is there a standard processing time that the Department considers normal such that there is no backlog of pending claims?

Mr. Perez:

Introduction

The Black Lung Benefits Act (BLBA), as amended, 30 U.S.C. 901-944, provides monthly payments and medical benefits to coal miners totally disabled by pneumoconiosis (Black Lung disease) arising from their coal mine employment. The Act also provides monthly benefits to eligible dependent survivors. Most approved claims are paid either by coal mine operators or their insurance carriers. The BLBA sets out the claims adjudication process, which is conducted in four steps: initial consideration by the Department of Labor's Office of Workers' Compensation Programs' (OWCP) district offices, formal hearings before the DOL Office of Administrative Law Judges (OALJ), appeals to the DOL Benefits Review Board (BRB), and subsequent review by the federal courts. This process protects the rights of all the parties. Although the claims adjudication process may be lengthy, deserving claimants are often paid benefits by the Black Lung Disability Trust Fund on an interim basis prior to final adjudication of their claims.

Initial Claim Adjudication by OWCP

OWCP administers the Black Lung program. OWCP's District Directors, whose offices are located around the country, develop evidence in claims for benefits under the BLBA, and conduct initial adjudications. OWCP offers all miners who file claims a complete pulmonary evaluation at the Department's expense. OWCP then considers this evidence, along with that submitted by the private parties, and enters a Proposed Decision and Order (PDO) adjudicating the claim. The PDO reflects OWCP's careful weighing of all the evidence relevant to responsible operator liability and whether the miner is totally disabled due to pneumoconiosis.

In FY 2015, a total of 2,631 PDOs had been issued by March 31. This fiscal year, 2,973 PDOs had been issued by March 31. Thus, OWCP effectuated a 13 percent increase in PDO processing this year. However, the average time to process each claim has increased from 268 days for fiscal year 2015 to 322 days for FY 2016. This increased processing time is due to several factors. First, applications for black lung benefits are increasing. OWCP received 6,818 claim filings in FY 2015, but is on pace to receive 7,400 in FY 2016. Second, because of increased claim filings, it is difficult for OWCP's cadre of qualified and dedicated physicians to meet the increased demand for DOL-sponsored complete pulmonary evaluations. Accordingly, the wait time for claimants to receive these pulmonary evaluations has increased, resulting in a corresponding increase in claim processing time. Third, administration of the program remains subject to sequestration, which reduces the funding we have available for staff.

In addition, OWCP has introduced new initiatives designed to enhance the quality of claims decisions, with an associated increase in average case processing time. For example, in FY 2014, OWCP launched a pilot program (BLBA Bulletin 14-05, February 24, 2014) to strengthen the credibility of certain complete pulmonary evaluations. Under the pilot program, if certain criteria are met, OWCP asks the doctor who conducted the initial examination to review any evidence submitted by the miner or the coal company and update his or her initial opinion in a supplemental report. Although the supplemental medical reports improve the credibility of the medical evidence, and therefore aid OWCP decision-making, they also add an average of 125 processing days to pilot program claims.

The Department has as a target 265 days for OWCP to process each Black Lung claim. The Department must also ensure accurate decision-making, however, so that deserving claimants receive benefits and liable coal mine operators are correctly named. The Department has therefore requested funding in FY 2017 that will better position OWCP to meet its claims-processing targets without sacrificing decision-making quality.

Formal Hearing before the OALJ

Any party dissatisfied with an OWCP PDO may request a formal adversarial hearing before the OALJ. In FY 2015, Responsible Mine Operators requested OALJ hearings on 80 percent (down from 89 percent in FY 2013) of the PDO approvals issued by OWCP.

In the second quarter of FY 2015, OALJ implemented the Black Lung Action Plan, the goal of which is to address the black lung backlog and adjudicate black lung claims more quickly. OALJ continues targeting its oldest pending cases, for example, 39 percent of the cases adjudicated through March of FY 2016 were more than three years old, 37 percent of the cases adjudicated in FY 2015 were also more than three years old as compared to 16 percent of FY 2014 cases.

Furthermore, the additional resources provided by Congress allowed OALJ to assign cases from hard to reach isolated locations not regularly visited by OALJ. These cases tend to be significantly older thereby further impacting OALJ average case age statistics.

While OALJ's concerted effort to address its oldest pending cases is the fair thing to do for the parties involved, the result of this policy is an increase of the average age of adjudicated cases. This increase is illustrated by the fact that the average age of a case adjudicated in FY 2014 was 690 days; in FY 2015 it was 902 days; and for the first half of FY 2016 it is 911 days. In other words, considering the Black Lung backlog and the additional resources now at OALJ's disposal, these figures show that OALJ is doing what it should be doing: prioritizing those cases most impacted by the backlog. OALJ has found the most useful tool for evaluating the success of the Action Plan to be a "pending cases to zero" figure. This "pending cases to zero" figure represents the number of months it would take OALJ to dispose of all Black Lung cases pending at the end of a fiscal year at the disposition rate for that fiscal year, assuming the receipt of no new Black Lung cases. OALJ's "pending cases to zero" long-term goal is 12 months. The peak of the backlog occurred in fiscal year 2014, when OALJ adjudicated 813 cases, with a "pending cases to zero" figure of 46 months for that fiscal year.

Due to the increased funding provided by Congress and the implementation of the Action Plan, in fiscal year 2015, OALJ adjudicated 1,088 cases, reducing the "pending cases to zero" figure from 46 months to 34 months. Through March 31 of this fiscal year, OALJ has adjudicated 777 cases, an 85 percent increase over the 420 cases adjudicated through March 31 in FY 2015. Accordingly, OALJ is on pace to meet its FY 2016 goal of 1,328 dispositions and thereby further reduce the "pending cases to zero" figure from 34 months to 26 months. By meeting its FY 2016 goals, OALJ will have achieved a 22 percent increase in Black Lung dispositions and a 26 percent decrease in the Black Lung backlog in FY 2016 as compared to FY 2015. Based on current projections, OALJ estimates that it will reduce the "pending cases to zero" figure to 18 months by fiscal year 2020 and reach its long-term goal of 12 months no later than FY 2023.

Appellate Review by the Benefits Review Board

Any party dissatisfied with a Decision and Order issued by the OALJ may file an appeal with the Benefits Review Board (BRB). Approximately 35 percent of OALJ Black Lung decisions are appealed. The BRB's goal is to decide all appeals from the OALJ within 12 months or less. In the second quarter of FY 2016, the average processing time was 11.76 months for Black Lung Cases. In the same quarter of FY 2015, the average processing time for Black Lung cases was 10.57 months, also exceeding BRB's goal. The BRB additionally strives to achieve an 85 percent affirmance rate in cases appealed to the United States Courts of

Appeals. The BRB has historically met or exceeded its timeliness and quality goals.

Recent increases in OALJ black lung disposition rates have resulted in increased black lung work for the BRB. Although the BRB has not received increased funding to support processing this increased workload, it has maintained its timeliness and quality goals.

Mr. Cole: Is the funding requested in the fiscal year 2017 budget projected to be sufficient to ensure that processing times remain reasonably close to the Department's goal?

Mr. Perez:

OWCP

In the FY 2017 Congressional Budget Justification, OWCP requested additional resources of \$600,000 and 5 FTE for Black Lung Field Operations Support and \$1,500,000 and 14 FTE for the Coal Miner Health Initiative. It also proposed restoration of \$2,397,000 sequestered in the FY 2016 enacted funding level. OWCP requests the additional resources in order to directly respond to the issues preventing it from meeting its black lung claims processing targets.

The request for Black Lung Field Operations Support and restoration of pre-sequestration funding will allow hiring additional black lung claims-processing staff, which will help the agency to issue timely and quality OWCP decisions.

In addition to addressing issues unrelated to claims processing times, the Coal Miner Health Initiative requests funding to recruit and train highly skilled physicians to conduct DOL-sponsored pulmonary evaluations. Recruiting and training additional physicians to conduct these evaluations will greatly speed claims processing at the OWCP level.

In sum, the FY 2017 funding request for OWCP is critical to ensuring timely processing of black lung claims without sacrificing the development and evaluation of the evidence necessary to quality decision-making.

OALJ

The President's fiscal year 2017 budget request, if enacted, would enable OALJ to remain on target to reach its long-term goal of reducing the "pending cases to zero" figure to 12 months by fiscal year 2023. Thus, this request is also critical to ensuring that the Department reaches its Black Lung claims processing goals.

BRB

The Board will continue to monitor workload trends to determine whether the increased OALJ black lung disposition rates impact the BRB's budgetary needs.

Mr. Cole: If not, what has changed in the Department's assumptions since formulating the fiscal year 2017 request?

Mr. Perez: The Department's assumptions have not changed since formulating the FY 2017 request.

MSHA RULE ON PROXIMITY DETECTION SYSTEMS

Mr. Cole: The Committee understands that NIOSH is currently undertaking a study to determine the efficacy of proximity detection systems for mobile machines in underground mines. Will MSHA wait for NIOSH to complete this study and incorporate any appropriate findings in its final rule on proximity detection systems?

Mr. Perez: MSHA published a Notice of Proposed Rulemaking (NPRM) on Proximity Detection Systems for Mobile Machines in Underground Mines on September 2, 2015. After holding a series of public hearings, MSHA received a request to extend the comment period. In response to this request, the end of the comment period for the NPRM was extended from December 1, 2015 to December 15, 2015. MSHA received considerable comments on the proposal for the development of a final rule. MSHA is currently analyzing these comments. MSHA will continue to work closely with NIOSH in the development of design parameters and performance guidelines for proximity detection systems in underground mines. MSHA will also apply lessons learned from the performance of these systems on continuous mining machines in underground coal mines as we develop the final rule for mobile machines.

STREAMLINING APPROVAL PROCESS FOR NEW MINING EQUIPMENT AND TECHNOLOGY

Mr. Cole: What actions is MSHA taking to improve and streamline its approval process for new mining equipment and technology?

Mr. Perez: MSHA approves and certifies new equipment, instruments, and materials to assure they do not introduce a source of explosion or cause a mine fire in an underground mine that puts miners at risk and can cause catastrophic damage. MSHA accepts approval applications submitted electronically through email or using file transfer protocol (FTP). MSHA's electronic submission process can accommodate common electronic document formats. Electronic submissions streamline the approval application process for manufacturers.

Under 30 CFR Part 7, MSHA will accept tests and evaluations performed by an independent laboratory, provided that MSHA product approval requirements

are followed. This third-party testing provides equipment manufacturers with an alternative to MSHA testing, which reduces waiting times. MSHA will also accept product approvals based on international standards under 30 CFR Part 6 (effective in 2003), if MSHA has determined the international standards are equivalent to MSHA standards. MSHA has evaluated one product (explosion-proof enclosure) based on international standards after determining that the international standards were equivalent to MSHA's. MSHA will continue to apply international standards to future approvals, as appropriate.

Mr. Cole: In what ways can MSHA expedite its approval process to ensure that miners have access to the latest in mining and mine safety equipment and technology?

Mr. Perez: Maintaining products in a condition that meets the MSHA approvals assures mine operators and miners that their use will not create a hazardous condition. We believe that equipment manufacturers' expanded use of third-party testing and voluntary consensus standards equivalent to MSHA standards can help to expedite new product approvals. MSHA continues to place increased emphasis on providing appropriate services to product manufacturers to ensure miners have access to the latest in mining and mine safety equipment and technology.

MSHA has already expedited approvals of many products including refuge alternatives, proximity detection systems, diesel engines and the Continuous Personal Dust Monitor. MSHA continues to look at ways to improve and expedite the approval process for technological advances.

DETAILS ON USE OF ADDITIONAL FUNDING PROVIDED TO BLS IN FY 2016

Mr. Cole: Please provide a table breaking out the actual or anticipated use of the additional \$16.8 million provided to BLS in the fiscal year 2016 Appropriations Act.

Mr. Perez: The 2016 Consolidated Appropriations Act provided a \$16,788,000 increase for the Bureau of Labor Statistics (BLS) over the fiscal year (FY) 2015 enacted level.

This increase partially funds inflationary costs as requested in the FY 2016 President's Budget, and also provides funding for the International Price Program (IPP) Export Price Indexes as shown in the table below. In the FY 2016 President's Budget, the BLS requested \$25.2 million for inflationary increases to maintain core programs. After restoring \$4.7 million in funding for the IPP Export Price Indexes, the remaining funding in the 2016 Consolidated Appropriations Act provided \$12.1 million for built-ins, or just under half of the requested

funding for inflation. This amount partially restored previous shortfalls, but did not fund any of the \$7.7 million for FY 2016 built-ins.

FY 2016 Increases (amounts in millions)	Enacted
Partial restoration of built-ins not provided under the Consolidated Appropriations Act level in FY 2014 and FY 2015	\$12.1
Restore Funding for International Price Program Export Indexes	\$4.7
Total increase over FY 2015 Enacted Level	\$16.8

DOL EVALUATION TRANSFER AUTHORITY

Mr. Cole: Please update the tables provided in fiscal year 2015 to show the actual amounts transferred in fiscal year 2015 and the planned transfer amounts for fiscal year 2016 under the Department's evaluation transfer authority, including the total amounts transferred from each account.

U.S. Department of Labor Transferred Obligations by Activity

Employment and Training Administration Training and Employment Services Account (160174) Obligations by Activity

Transfers-Out:

Activity	FY 2015 Appropriation	Post Transfer Level	Proposed Transfer (+) or (-)
Training and Employment Services	\$3,139,706,000	3,131,857,000	-\$7,849,000
Adult Employment and Training	\$776,736,000	\$774,593,000	-\$2,143,000
Youth Activities	\$831,842,000	\$829,547,000	-\$2,295,000
Dislocated Worker			
Employment and Training Activities Dislocated	\$1,015,530,000	\$1,012,728,000	-\$2,802,000
Worker National Reserve	\$220,859,000	\$220,250,000	-\$609,000
All other TES accounts	\$294,739,000	\$294,739,000	\$0

Employment and Training Administration Office of Job Corps Account (160181)

Obligations by Activity**Transfers-Out:**

Activity	FY 2015 Appropriation	Post Transfer Level	Proposed Transfer (+) or (-)
Office of Job Corps	\$1,688,155,000	\$1,683,935	-\$4,220,000

**Employment and Training Administration
Community Service Employment
Account (160175)
Obligations by Activity**

Transfers-Out:

Activity	FY 2015 Appropriation	Post Transfer Level	Proposed Transfer (+) or (-)
Community Service Employment	\$434,371,000	\$433,285,000	-\$1,086,000

**Employment and Training Administration
State Unemployment Insurance and Employment Service Operations
Account (160179)
Obligations by Activity**

Transfers-Out:

Activity	FY 2015 Appropriation	Post Transfer Level	Proposed Transfer (+) or (-)
State Unemployment Insurance and Employment Service Operations	\$3,597,150,000	\$3,588,157,000	-\$8,993,000
SUIESO/State Operations	\$2,684,793,000	\$2,677,584,000	-\$7,209,000
SUIESO/ES Grants to States	\$664,184,000	\$662,400,000	-\$1,784,000
All other SUIESO accounts	\$248,173,000	\$248,173,000	\$0

**Departmental Management Salaries and Expense Account
Obligations by Activity**

Transfers-Out:

Activity	FY 2015 Appropriation	Post Transfer Level	Proposed Transfer (+) or (-)
----------	-----------------------	---------------------	------------------------------

1.Program Evaluation	\$8,040,000	\$30,188,000	\$22,148,000
----------------------	-------------	--------------	--------------

Mr. Perez: There is no update to the FY 2015 transfers; the table included in the QFR is complete. See below for the planned transfers for FY 2016.

**U.S. Department of Labor
Transferred Obligations by Activity**

Employment and Training Administration			
Training and Employment Services			
Account (160174)			
<u>Transfers-Out</u>			
Activity	FY 2016 Appropriation	Post Transfer Level	Proposed Transfer (+) or (-)
Training and Employment Services	\$3,335,425,000	\$3,327,086,000	-\$8,339,000
Adult Employment and Training	\$815,556,000	\$813,235,000	-\$2,321,000
Youth Activities	\$873,416,000	\$870,931,000	-\$2,485,000
Dislocated Worker Employment and Training Activities	\$1,020,860,000	\$1,017,955,000	-\$2,905,000
Dislocated Worker National Reserve	\$220,859,000	\$220,231,000	-\$628,000

Employment and Training Administration			
Community Service Employment			
Account (160175)			
<u>Transfers-Out</u>			
Activity	FY 2016 Appropriation	Post Transfer Level	Proposed Transfer(+ or -)
Community Service Employment	\$434,371,000	\$433,285,000	-\$1,086,000

Employment and Training Administration			
Office of Jobs Corps			
Account (160181)			
<u>Transfers-Out</u>			

Activity	FY 2016 Appropriation	Post Transfer Level	Proposed Transfer(+) or (-)
Office of Job Corps - Operations	\$1,581,825,000	\$1,577,602,000	-\$4,223,000

Employment and Training Administration			
State Unemployment Insurance and Employment Service Operations			
Account (160179)			
<i>Transfers-Out</i>			
Activity	FY 2016 Appropriation	Post Transfer Level	Proposed Transfer(+) or (-)
State Unemployment Insurance and Employment Service Operations	\$3,589,878,000	\$3,580,903,000	-\$8,975,000
SUIESO/State Operations	\$2,627,550,000	\$2,620,420,000	-\$7,130,000
SUIESO/ES Grants to States	\$680,000,000	\$678,155,000	-\$1,845,000

Departmental Management			
Salaries and Expenses			
Accounts (16 16/17 0165)			
<i>Transfers-In</i>			
Activity	FY 2016 Appropriation	Post Transfer Level	Proposed Transfer(+) or (-)
Departmental Program Evaluation	\$8,040,000	\$30,663,000	\$22,623,000

DOL PROGRAM EVALUATION ACTIVITIES

Mr. Cole: What evaluation activities has the Department undertaken with fiscal year 2015 funds and what are the anticipated evaluations the Department expects to undertake with fiscal year 2016 funds? Please also provide estimated costs of each evaluation activity.

Mr. Perez: The following evaluation activities have been initiated with Fiscal Year 2015 Departmental Program Evaluation and set-aside funds:

- Clearinghouse of Labor Evaluation and Research (CLEAR) and CLEAR Evidence Reviews 2015 - \$1.3 million

- The National Guard Youth ChalleNGe Job ChalleNGe Evaluation Demonstration - \$1.1 million
- Youthbuild Evaluation-Followup Surveys - \$2.3 million
- National Agricultural Workers Survey - \$2 million
- University of Maryland Worker Protection Study and Research Meeting - \$60,000
- Institutional Analysis of American Job Centers - \$500,000
- Youth Career Connect Evaluation - \$1.1 million
- Study of Best Practices in Promoting Diversity in Employment in First Responder Occupations - \$500,000
- Study of Customer Experience in American Job Centers - \$470,000
- Administrative Data Research and Analysis Projects (2) \$2 million
- Chief Evaluation Office Evaluation Support 2015 - \$700,000
- Customer Satisfaction Study of ODEP Technical Assistance Centers - \$1.4 million
- DOL Academic Research Scholars Project - \$1.5 million
- Special Topics in Farm Labor Research - \$50,000
- Study on Older Workers Labor Market Decisions - \$500,000
- Linking to Employment Activities Pre-Release Evaluation Phase 1 - \$750,000
- Middle Skills Study - National Academy of Science - \$75,000
- ILAB - Livelihoods Project Evaluation - \$1.4 million
- Performance Partnership Pilots Evaluation (P3) Round 1 Grants - \$2.3 million
- Study of the Urban Youth Grants - \$540,000
- Bureau of Labor Statistics Displaced Worker Survey - \$670,000
- Behavioral Insights/Behavioral Economics Studies 2015 - \$125,000
- Unemployment Insurance Technical Evaluation Working Groups - \$450,000
- ILAB Strategy Development - National Academy of Science - \$50,000
- Evaluation of the Cascades Job Corps Center Innovation Demonstration - \$3 million
- Career Pathways Study Design - \$550,000
- Bureau of Labor Statistics Contingent Worker Survey - \$950,000
- Department of Health and Human Services for California Paid Leave Analysis - \$50,000
- Department of Health and Human Services for Paycheck Plus Demonstration Evaluation - \$500,000
- Wage Record Data Exchanges for DOL Evaluations 2015 - \$160,000

For Fiscal Year 2016, the Department anticipates funding the following evaluations using both Departmental Program Evaluation and set-aside funds (please note that funding estimates are provided in ranges as actual costs could vary considerably depending on the design, study priorities and new information):

- Feasibility Analysis of Consumer Information on Training Programs (\$250,000 - \$500,000)
- Wave 3 Family and Medical Leave Act Survey (\$2.5 million - \$3.5 million)
- Analysis of Unemployment Insurance Non-Filers (\$750,000 - \$1.25 Million)
- Clearinghouse for Labor Evaluation and Research (CLEAR) and CLEAR evidence reviews 2016-2018 (\$2 million - \$3 million)
- BLS Employer Sponsored Training Survey (\$300,000 to \$500,000)
- Analysis of the Implementation of WIOA (\$2.5 million - \$3.5 million)
- WIOA Services to Employers (\$250,000 - \$500,000)
- Literature Review of Evidence on Workers' Rights Programs (\$250,000 - \$500,000)
- Impact Evaluation of Girls Empowerment Project in Africa (\$750,000 - \$1.25 Million)
- Chief Evaluation Office Evaluation Support 2016 (\$700,000)
- Outcome Study of the Effects of Technical Assistance to Reduce Child Labor (\$250,000 - \$500,000)
- Evaluation of the Effectiveness of ODEP's Technical Assistance (\$750,000 - \$1 Million)
- Study of Pay Equity in Non Traditional Occupations and Employment Programs (\$250,000 - \$500,000)
- Training to Work Grants Implementation Study (\$250,000 - \$500,000)
- Review and Assessment of Job Corps Services to Youth, Evidence-based Strategies, and Program Structure (\$500,000 - \$1 million)
- Implementation Study of Corporate Policies on Disability and Inclusion (\$250,000 - \$500,000)
- Employment and Career Services for Victims of Forced Labor and Human Trafficking (\$250,000 - \$500,000)
- Analysis of Worker Benefits and Retirement Models, Programs, and Consumer Tools (\$500,000 - \$750,000)
- Review of Unemployment Insurance Payment and Benefit Models (\$250,000 - \$500,000)
- Evaluation of the Performance Partnership Pilots (P3) for Disconnected Youth Evaluation of Rounds 2 and 3 grantees (\$1 million - \$2 million)
- Youth Build Evaluation Followup and Final Analysis - (\$2.5 million - \$3.5 million)
- Evaluation of TechHire and Strengthening Working Families Initiative grants programs (\$2.5 million - \$3.5 million)
- Evaluation of the Linking to Employment Activities Pre-Release Pilots (LEAP) Rounds 2 and 3 (\$1 million - \$2 million)
- Field-initiated Employment Models for Formerly Incarcerated Individuals (\$1 million - \$2 million)
- Pathways to Justice Evaluation (\$500,000 - \$1 Million)
- Homeless Veterans Reintegration Program Evaluation Expansion (\$750,000 - \$1.25 Million)

- Evaluation of Employment Strategies for Persons with Disabilities in Community Colleges (\$1 million - \$2 million)
- Evaluations Using Behavioral Insights/Behavioral Economics to Improve Program Outcomes 2016-2017 (\$1 million to \$2 million)
- Evaluation of Health Impacts of Mining (\$250,000 - \$500,000)
- Evaluation of the “Pay Check Plus” Demonstration (\$500,000)
- Wage Record Data Exchanges for Evaluations 2016 (\$200,000 - \$400,000)

Mr. Cole: How much additional funding does the Department anticipate setting aside for evaluations in fiscal year 2017 if the transfer authority is increased to 1 percent as requested?

Mr. Perez: At this time, it is not possible to forecast the exact amount of the evaluation set-aside we would use in FY 2017. The decision on how much to set aside is based on recommendations from the Chief Evaluation Office after the annual “learning agenda” process is completed with each of DOL’s operating line agencies. The Chief Evaluation Office develops the 5 Year Learning Agendas with each Agency to set out a strategy to develop evidence on what works in Agency programs, operations and new initiatives. The Agendas also incorporate current Agency priorities, operating plans, new initiatives, and legislative requirements or recommendations (e.g., in the Workforce Innovation and Opportunity Act, Congress recommends or requires several evaluations, which will be a priority for set-aside funding). An increase in the transfer authority to 1% would allow the Department to consider more comprehensive evaluations of additional programs and initiatives that current resources may not allow, as noted in the following answer.

Mr. Cole: What evaluation activities does the Department plan to undertake with the additional funding?

Mr. Perez: With an increase of the transfer authority to 1 percent, the Department would be able to conduct larger randomized controlled trials of the impact of DOL programs, pilots, demonstrations, and new initiatives. For example, more resources would allow for larger sample sizes in impact evaluations and surveys to increase both the statistical precision of impact estimates and allow for more robust sub-group analysis of different populations of interest (e.g., youth, dislocated workers, older workers). The additional resources would also allow for more field-based qualitative program implementation evaluations, which typically require labor-intensive data collection (e.g., ongoing evaluations of the Workforce Innovation and Opportunity Act programs and services; studies of services to veterans). The Department would be able to include additional sites and programs to increase both geographic representativeness and the external validity of these studies.

GOLD STANDARD EVALUATION OF WORKFORCE TRAINING PROGRAMS

Mr. Cole: Please provide an update on the status and expected release date of the Gold Standard evaluation of the Department's workforce training programs.

Mr. Perez: The forthcoming implementation report and related briefing papers will be available in early summer 2016 and provide a snapshot of how the Workforce Investment Act (WIA) Adult and Dislocated Worker programs were operating nationwide in the early 2010s. Early findings from the evaluation substantiate a number of the changes instituted under Workforce Innovation and Opportunity Act (WIOA) that provide more flexibility to local areas to better serve their clients based on their immediate needs, existing strengths and skills. The qualitative data described in that report is based on analysis of 28 different local areas across 19 states and will provide insights about various practices or approaches that will help states and local areas improve service quality.

Two impact reports are scheduled for release in 2017 and 2018; they will provide information about the effectiveness of workforce services at 15 months and 30 months, respectively, after participants were randomly assigned into the study. The final report also will provide the results of the cost-benefit analysis. While this evaluation is of WIA, there are significant parallels to the service-delivery structure under the Workforce Innovation and Opportunity Act, which superseded WIA, and will be relevant under WIOA.

In addition, the Department has already released two reports associated with WIA Gold Standard Evaluation (WGSE): Evaluating National Ongoing Programs: Implementing the WIA Adult and Dislocated Worker Programs Gold Standard Evaluation^[1]; and Providing Services to Veterans Through the Public Workforce System: Descriptive Findings from WIA Gold Standard Evaluation: Volume I and Volume II^[2].

The Veterans Service Study (VSS) report provides information about different ways in which the public workforce investment system provides services to veterans through American Job Centers (AJC). In addition, it describes the characteristics of veterans receiving services through the AJC system, the services they receive, and their outcomes. Among other things the report reveals:

- Veterans were not always aware of priority of service or services available when they entered an AJC.
- AJC staff, including WIA staff and veterans' representatives funded by Jobs for Veterans State Grants, reported that a key activity was translating veterans' military experience to civilian job opportunities.

^[1] http://wdr.dol.gov/research/keyword.cfm?fuseaction=dsp_resultDetails&pub_id=2572&mp=y

^[2] http://wdr.dol.gov/research/keyword.cfm?fuseaction=dsp_resultDetails&pub_id=2569&mp=y

- The report also includes an in-depth analysis of administrative data from two states, which allowed the evaluation team to correlate service receipt with veterans' average post-program quarterly earnings.

Mr. Cole: Please also describe how the evaluation will incorporate or assess new core performance criteria enacted under WIOA.

Mr. Perez: Given the timing of the study, it is focused on participant outcomes under WIA, and not the WIOA performance criteria. However, it will be informative for implementation of WIOA. Early findings from the evaluation substantiate a number of the changes instituted under WIOA that provide more flexibility to local areas to better serve their clients based on their immediate needs, existing strengths and skills. The qualitative data described in the report will provide insights about various practices or approaches that will help states and local areas improve service quality.

While the impact results are scheduled for release in early 2017 and in 2018, the series of implementation study briefs and findings will help states and localities as they continue to implement WIOA. During the next several years, state and local officials and workforce development boards will have many opportunities to use the results from the WGSE to improve practices and the quality and types of services offered through AJCs.

OVERTIME RULE

Mr. Cole: How will the Department ensure that the final overtime rule does not disproportionately impact lower income and rural areas of the country?

Mr. Perez: The Department received 270,000 comments about the proposed rule, including comments from employers in lower income and rural areas about the impact it would have. While many commenters agreed that the current standard salary level is too low, a number of employers or their representatives objected to the Department's proposed overtime rule, which proposed to set the standard salary level at the 40th percentile of weekly earnings of full-time salaried workers nationally. Such commenters asserted that the proposed salary level was too high and would provide overtime protection to too many bona fide executive, administrative, or professional employees; particularly in low-wage regions and industries. In requesting that the Department establish a lower salary level in the final rule, some of these commenters suggested, for example, that the Department should set the salary at a lower level to account for lower wage regions or industries. In response to these concerns, the Department set the level in the final rule at the 40th percentile of full-time salaried workers in the lowest wage Census region — currently the South — instead of the 40th percentile nationally, as proposed in the NPRM. The Department is confident that this salary level will work across a broad range of regions, industries, and business sizes and will ensure workers receive the protections the law was meant to provide.

IMPLEMENTATION OF EO 13673

Mr. Cole: Please provide a table listing all funding amounts and FTE that are being requested in the fiscal year 2017 budget and are proposed to be used to assist with the implementation of Executive Order 13673 “Fair Pay and Safe Workplaces.”

Mr. Perez: Please see the table below for the funding and FTE included in the FY 2017 budget to assist with implementation of Executive Order 13673. Within the Departmental Management’s Program Direction and Support activity, \$2.6 million is requested to assist with implementation of the Order. The resources will be used to facilitate cross-agency sharing of enforcement data and information to improve the targeting of enforcement and compliance assistance efforts; the resources will not be used to create a new office to implement the Order.

Funding to Assist with E.O. 13673 (Dollars in Thousands)

Agency	Program	Funding	FTE
Departmental Management/ Program Direction and Support	Implementation of Fair Pay and Safe Workplaces Executive Order	\$2,620	15
	Total	\$2,620	15

CHEMICAL FACILITY SAFETY AND SECURITY

Mr. Cole: Will the Department propose any regulatory changes pursuant to the April 2013 Executive Order 13650 “Improving Chemical Facility Safety and Security?”

Mr. Perez: As a result of Executive Order 13650, OSHA is currently conducting preliminary rulemaking activities to explore possible changes to its Process Safety Management Standard. OSHA has started the Small Business Regulatory Enforcement Fairness Act (SBREFA) process to solicit comments from small entity representatives on several regulatory alternatives being considered. We issued a background document to small employer representatives and plan to convene the panel in June. OSHA’s PSM SBREFA webpage, <http://www.osha.gov/dsg/psm/index.html>, lists the topics being considered. The SBREFA process will include consideration of the NAICS-based definition of retail facility announced in OSHA’s July 2015 interpretive guidance.

In addition, the National Advisory Committee on Occupational Safety and Health has formed a subcommittee to work with the agency to draft potential regulatory language regarding Emergency Response and Preparedness for workplace emergency responders. The NACOSH subcommittee has met several times this year and is scheduled to meet within a few weeks.

OSHA will review the information from these preliminary activities to decide how to develop rulemaking proposals.

Questions for the Record from Mr. Fleischmann**PROPOSED RULE CHANGES TO EEOICPA**

The Office of Workers Compensation program has published a notice of proposed rule changes to the Energy Employees Occupation Illness Compensation Program Act. I'd like to ask a series of questions to clarify these proposed changes. The proposed rule changes alerts medical providers that DOL may adopt the home health prospective payment system which was devised by the centers for Medicare and Medicaid services within HHS.

Mr. Fleischmann: How will this proposed rule change, if implemented, alter the existing method of paying for home health services and how will it affect the quality of care?

Mr. Perez: As you correctly state, one of the proposed changes to the regulations includes giving the Department authority to review the Home Health Prospective Payment System that was devised by the Centers for Medicare and Medicaid Services (CMS) within the Department of Health and Human Services to determine whether there are portions of that system that may be useful to more effectively manage the program. It is not our intent to implement any changes in such a way that would impact the quality of care. The comment period for this rule was reopened effective April 5, 2016, and closed on May 9, 2016. This extension provided stakeholders additional time to address any issues or concerns they may have with the changes to Subpart H or any of the other proposals.

Mr. Fleischmann: In other words, will the payments to health care providers be less than they are currently or will fewer services be authorized?

Mr. Perez: As noted in the previous answer, the pertinent proposed change would not, in and of itself, reduce payments to certain health care providers. Rather, it would merely inform the public of the possibility that the process for determining the maximum fees payable to those providers may, in the future, be altered.

Mr. Fleischmann: Will payments for the same services be delayed?

Mr. Perez: No, these payments would not be delayed as a result of the proposed changes.

Mr. Fleischmann: If yes, would this not be a disincentive for providers to participate in the care and management of sick workers, many of whom have several chronic medical problems?

Mr. Perez: The payments would not be delayed, so this is not applicable.

Mr. Fleischmann: Some providers in the area do not accept Medicare. Does it therefore make sense to apply Medicare payment standards to a program which is supposed to supplement medical services for disease-ridden atomic energy workers?

Mr. Perez: It is not our intent to apply the entire Medicare usage standards to the Energy Employees Occupational Illness Compensation Program.

Nevertheless, the comment period for these regulations was reopened from April 5, 2016 to May 9, 2016 for any interested stakeholders to submit additional comments or concerns regarding these changes. The Department will carefully review and consider all comments submitted in the public comment process.

Mr. Fleischmann: What input, if any, did the Department of Labor receive from local doctors, for example, in the East Tennessee area, or home health agencies, in formulating any of the proposed rules relating to medical services?

Mr. Perez: The comment period for these regulations was previously extended by 30 days and recently was reopened for an additional period from April 5 to May 9, 2016, giving the public, including local doctors and home health agencies, an additional opportunity to comment. The Department will carefully review and consider all comments that are submitted.

Mr. Fleischmann: Does DOL know if such providers would be willing to agree to provide services under the Home health prospective payment system?

Mr. Perez: As noted above, the comment period for these regulations was extended to May 9, 2016, giving providers an additional opportunity to comment. The Department will carefully review and consider all comments that are submitted.

Mr. Fleischmann: Are there any provisions in the proposed rule changes which would limit physician choices by beneficiaries? Section 30.405 (b) appears to do that. This is concerning because some of the beneficiaries have multiple health conditions which require treatment from multiple specialists.

Mr. Perez: The EEOICPA statute specifically provides that the claimant is entitled to the initial choice of physician in Section 7384t, and there are no proposed changes in the regulations that would affect that initial choice. The Department has proposed changes to the regulations relating to requests to change physicians. The current regulations (30.405(b)) say "OWCP will approve the request [to change physicians] if it determines that the reasons submitted are sufficient." The proposed rule changes "sufficient" to "credible and supported by probative factual and/or medical evidence, as appropriate." The proposed rule replaces a general term with specific terms to provide claimants with better notice of the type of information needed to change a physician but does not constitute the imposition of any new "limits." It also would hold OWCP to a specific

standard, which would make it easier for claimants to challenge denials of requests under Section 30.405(c), should a claimant feel that the proposed standard was not met by DOL. If a claimant provides the necessary information to justify the change in physician, the claimant could choose any physician they want. Section 30.405(c) would continue to allow a claimant who disagrees with the denial of a request to change doctors to utilize the adjudicatory process.

Mr. Fleischmann: I would like a more detailed briefing on these proposed changes and would request briefings for local medical providers as well. Do you have any plans to work with medical providers in communities with large groups of sick workers?

Mr. Perez: Per your request, OWCP Director Leonard Howie and Associate Solicitor Thomas Giblin met with your staff on April 19th and briefed them on the changes in our proposed rule. As your staff was advised in that meeting, given that we are in the middle of a formal rulemaking we encouraged all medical providers or other interested parties to formally submit comments which will be considered by the Department. After the rule is finalized the Department will be happy to meet with medical providers and other stakeholders; these stakeholders are also welcome to provide formal feedback as part of the EO 12866 process.

Questions for the Record from Ms. Roby**CONTINUING THE VPP AND OTHER RELATED PROGRAMS**

In previous testimony, you have noted that OSHA is committed to improving its compliance assistance activities to ensure workers and businesses are educated about, and involved in, improving workplace safety and health. The Voluntary Protection Program, better known as VPP, which you mentioned last year, is a cooperative program intended to encourage employers to implement a comprehensive safety and health management system. Worksites with effective systems and low injury and illness rates relative to their respective industry are accepted into VPP, and are then exempt from programmed OSHA inspections. The Safety and Health Achievement Recognition Program (SHARP), which primarily focuses on small businesses, is designed to provide incentives and support to those employers that implement and continuously improve effective safety and health management systems at their worksite. SHARP participants are exempted from OSHA programmed inspections for at least one year. In my state, the University of Alabama System has implemented the Safe State Occupational Safety and Health Consultation Program. This program helps qualified businesses in Alabama enter into the SHARP and VPP programs. The Safe State program is facilitating OSHA compliance for large, medium, and small businesses around Alabama and the nation. The FY17 Department of Labor budget request states that “OSHA will continue to improve the Voluntary Protection Program (VPP) in FY 2017 with special emphases on program consistency and oversight, data integrity, and reevaluation of policies for VPP sites with injury and illness rates higher than industry averages.”

Ms. Roby: Has the Labor Department produced a report which evaluates the effectiveness of these OSHA compliance programs?

Mr. Perez: Pursuant to language in the House report accompanying the Consolidated Appropriations Act of 2016 (P.L. 114-113) directing OSHA to submit a report to the House and Senate Committees on Appropriations assessing the participation, detailed costs, and effectiveness of VPP, DOL is in the final stages of clearing a report for submission to Congress.

Ms. Roby: If so, could you please provide me a copy of the report? If not, then I would like you to submit a report to this committee that determines the effectiveness of the OSHA compliance programs, that I just described, and how we can streamline and better use those programs.

Mr. Perez: We will provide a copy of the VPP report to the Committee as soon as it is completed, and would be happy to arrange for a briefing on SHARP to respond to any additional information the Committee would like about our compliance assistance efforts.

COORDINATION WITH DEPARTMENT OF EDUCATION ON JOB DRIVEN TRAINING AGENDA

Two years ago, Congress demonstrated a bipartisan commitment to generating more pathways into the workforce for dislocated workers, at-risk youth, and veterans with the bipartisan Workforce Innovation and Opportunity Act (WIOA). The goal of this legislation is to improve the nation's job training system by emphasizing career pathways, empowering job seekers, and directing more resources to at-risk youth. With that spirit of collaboration in mind, I am interested in how the Department of Labor has collaborated with the Department of Education to streamline and focus on the job driven training proposals. In the FY 2017 budget request, the Job Driven Training Proposals include the American Talent Compact, which requests \$3 billion over five years; the Career Navigators and WIOA Data Science and Innovation Fund requests \$2 billion over five years; and the Opening Doors for Youth proposal calls for \$5.5 billion over four years. All of these proposals seek to close the skills gap by bringing together potential employees with the training and information they need to engage potential employers. Many of the proposals I have mentioned seek to alleviate the problems that arise when someone drops out of the workforce or cannot enter the workforce due to a training or skills deficit. Thinking in the long-term, it is essential that we prevent this situation from happening to begin with. That's why I am interested in hearing how you plan to partner with the Department of Education to reach at-risk youth, in and out of school, to create career pathways while students are still in school. From my perspective, partnering with Career Tech Education and other programs that offer direct career pipelines for students would be a very useful place to start these efforts.

Ms. Roby: Please expound on how the Department of Labor will collaborate with the Department of Education and private employers to implement the American Talent Compact, Career Navigators, and Opening Doors for Youth to create public awareness about these programs and to form career pipelines for our young people?

Mr. Perez: The Departments of Labor and Education (ED) have been collaborating successfully for the past several years to advance career pathways and the alignment of secondary and postsecondary education and training opportunities for youths and adults, and have collaborated on several competitive grant initiatives to advance job driven training. In addition to these efforts, since July 2014, DOL has worked with ED to implement the Workforce Innovation and Opportunity Act (WIOA), which has included work to help address the needs of at-risk youth.

Building on the work of many past joint initiatives across the two agencies, such as Youth CareerConnect, Performance Partnership Pilot grants, and Career Pathways, the DOL and ED will collaborate closely to provide both guidance and technical assistance in the implementation of the American Talent Compact,

Career Navigators, and Opening Doors for Youth initiatives. The Departments will promote awareness of these initiatives to a wide range of education and workforce stakeholders across the country. The Departments will also encourage greater partnerships with employers to build new or strengthen existing programs that provide youth and adults with connections to career pathway opportunities. The Departments also are developing and will release over the coming months technical assistance documents that help both education and workforce development stakeholders build new or strengthen existing relationships, align policies, and leverage resources to better serve both in-school and out-of-school youth to help them successfully achieve education and career goals. These technical assistance documents also will focus on strategies for youth sub-populations such as homeless, foster and justice-involved youth, as well as youth with disabilities. Below is additional information on past partnerships between DOL and ED that we would seek to expand.

Career Pathways:

- In April 2012, the U.S. Departments of Labor, Education, and Health and Human Services formed a Federal partnership and issued a letter of joint commitment to promote the use of Career Pathways to assist youth and adults with acquiring marketable skills and industry-recognized credentials through better alignment of education, training and employment, and human and social services among public agencies and with employers. Building on the work of our three Departments, we've expanded support to multiple agencies that are promoting alignment among their public workforce, education, and social and human services systems under the auspices of Secretary Perez's Skills Working Group.
- DOL, working with these other agencies, is using the new definition of Career Pathways included in WIOA and the common framework developed originally by the Departments of Labor, Education and Human Services. Through this work, the Administration is demonstrating its continued commitment to promote Career Pathways, providing updated information and resources from the expanded Federal partnership to help States, regions, local entities, and tribal communities integrate service delivery across Federal and State funding streams.

Job-Driven Investments:

- DOL and ED have worked closely through Trade Adjustment Assistance Community and Career College Training (TAACCCT) and other competitive grant initiatives and special projects, such as Youth CareerConnect and Performance Partnership Pilots. The Departments welcome the opportunity to work with one another in administering the mandatory proposals put forth in the budget.
- DOL and ED have worked closely on program policy, design, and technical assistance. Future collaborations can build on this experience,

- including access to performance reporting and fiscal systems, product submission systems, and partnerships with external service providers and other Federal agency stakeholders.
- Joint administration has also enabled the use of a regional oversight and accountability structure that will help ensure the successful outcomes of the grants.

The Departments intend to continue to collaborate on our work that may include competitive grant solicitations, outcome and progress measures, guidance, technical assistance, and monitoring.

Questions for the Record from Ms. Roybal-Allard**HAZARDOUS OCCUPATION ORDERS FOR TEEN WORK ON FARMS**

Ms. Roybal-Allard: In the wake of the Obama Administration's withdrawal of hazardous occupation orders for teen work on farms in 2012, what is the Department of Labor doing to protect child workers from obvious dangers on farms?

Mr. Perez: One of the highest priorities of the Department of Labor's Wage and Hour Division (WHD) is to ensure that children are protected from illegal employment in prohibited hazardous occupations, and that those who are eligible to work have safe and appropriate work experiences. WHD looks for child labor in every one of its investigations, including agriculture. WHD conducted nearly 1,400 investigations in agriculture in FY 2015.

Agricultural work is difficult and dangerous for all farm workers, but child farm workers are among the most vulnerable of our nation's workers. Too many children under the age of 16 who work in agriculture are injured or killed on the job.

WHD has undertaken a number of initiatives in collaboration with stakeholders to educate, train and protect workers, including young workers, in addition to strategically enforcing the existing rules for this industry. This includes focusing our directed investigations on low wage industries, including agriculture, and vigorously using the tools provided us under our nation's worker protection laws to increase compliance, keep farm workers safe on the job, and ensure a level playing field so that the many responsible growers are not put at a competitive disadvantage for abiding by the law.

WHD regularly engages the agricultural community in order to provide information and compliance assistance to employers who want to comply with the law, including meeting with employers, speaking to trade associations, and conducting webinars. Since FY 2009, WHD has conducted nearly 1,000 outreach events and presentations nationwide geared to provide valuable information and compliance assistance to the agricultural industry, including information on existing child labor laws. WHD has also hired Community Outreach and Resource Planning Specialists (CORPS) to work in the agency's district offices to enhance the ability to get this information to those who need it, including those in the agricultural industry. An example of this active outreach is WHD's District Office in North Carolina. The North Carolina office is an active member of the Farm Labor Practices Group (FLPG). The FLPG is a multi-stakeholder initiative that was launched in 2012 to improve farm labor practices by helping both farmers and farmworkers in labor intensive crop activities, such as tobacco, to better understand and comply with applicable labor laws and regulations.

The Occupational Safety and Health Administration's (OSHA) safety and health regulations apply to all employees regardless of age. As a result, OSHA does not have any specific regulatory requirements focused on minors. However, OSHA developed and maintains a *Youth in Agriculture e-Tool*^[1] describing common agricultural hazards and offers potential safety solutions that both employers and young workers can use to prevent or eliminate farm-related hazards and avoid injuries on farms.

In terms of coverage of farms, the Consolidated Appropriations Act of 2016 precludes OSHA from expending appropriated funds to conduct enforcement activities with respect to any person engaged in a farming operation with 10 or fewer employees that has not maintained a temporary labor camp within the preceding twelve months. This limitation, commonly known as the "small farm exemption," has been in effect since 1976.

CHILD LABOR IN TOBACCO

In early 2015, the Department of Labor convened a meeting regarding child labor in tobacco between tobacco companies and non-governmental organizations. In this meeting, tobacco companies announced internal buying policies to ban child work in tobacco fields for children under 16. However, these policies are only voluntary.

Ms. Roybal-Allard: Does the Department of Labor intend to monitor the effectiveness of these policies?

Mr. Perez: The Department takes the issue of children employed in the tobacco industry seriously, and has taken steps to help protect their health and safety. In March 2015, Secretary Perez, along with senior officials at the Department of Labor and the White House, met with representatives of the tobacco industry and worker representatives to discuss steps to curtail child labor in tobacco farming. During the meeting, the Secretary encouraged the industry to take additional steps to curtail child labor in tobacco farming and to better protect young workers. The Department continues to enforce the existing federal child labor standards that apply to the agriculture industry, including tobacco farming. At the same time, the Department is working with associations, employers, and workers to provide education, compliance assistance, and training to ensure that workers are employed in compliance with federal labor and health and safety standards. These efforts include encouraging companies at the top of supply chains to evaluate the compliance practices of those below them to ensure labor standards are met.

Specifically, the Wage and Hour Division's (WHD's) District Office in North Carolina is an active member of the Farm Labor Practices Group (FLPG). The FLPG is a multi-stakeholder initiative that was launched in 2012 to improve farm

^[1] <https://www.osha.gov/SLTC/youth/agriculture/index.html>

labor practices by helping both farmers and farmworkers in labor intensive crop activities, such as tobacco, to better understand and comply with applicable labor laws and regulations. The FLPG brings together key stakeholders from the industry including growers, farmers, workers and their representatives, manufacturers, and others who sell agricultural products to facilitate constructive dialogue about farm labor practices. WHD is active in the FLPG's Training and Education Work Group and has helped develop a variety of educational materials. WHD is also working with the FLPG to provide enhanced training on labor-related issues at locations of Good Agricultural Practices (GAP) training events. In 2015, WHD personnel participated in over 100 training sessions in 12 states and reached approximately 10,000 growers. In FY 2015, GAP trainings also included a discussion on the importance of farmworker protections against Green Tobacco Sickness, a type of nicotine poisoning.

The Occupational Safety and Health Administration (OSHA) is also a key leader in the effort to protect the health and safety of children employed in the tobacco industry. OSHA's safety and health regulations apply to all employees regardless of age, so OSHA has no specific regulations regarding minors. However, OSHA developed and maintains a Youth in Agriculture e-Tool^[1] describing common agricultural hazards and offering potential safety solutions that both employers and young workers can use to prevent accidents and avoid injuries on farms. In addition, OSHA also maintains a Safety and Health Topics page on Green Tobacco Sickness and jointly developed with the National Institute for Occupational Safety and Health the bulletin, "Recommended Practice: Green Tobacco Sickness,"^[2] which provides information about the illness and the associated health hazards. OSHA's Regional and Area Offices regularly conduct outreach activities for the agricultural sector, and conducted more than 200 such activities in FY 2015.

OSHA participates on two taskforces specifically dedicated to the safety and health of agricultural workers. The DOL Agriculture Taskforce includes national office and field representatives from OSHA, WHD and ETA. This group meets every two months to discuss new guidance products; upcoming outreach opportunities; as well as completed outreach activities; jurisdictional issues; and any trends in injuries, illnesses or fatalities. The Cross Agency Agriculture Taskforce includes the members of the DOL Agriculture Taskforce as well as representatives from the U.S. Department of Agriculture, NIOSH and the Environmental Protection Agency. This group meets three to four times a year to discuss new Agency initiatives, the promulgation of standards, and dissemination of information.

ILAB CHILD LABOR PROGRAMS

^[1] <https://www.osha.gov/SLTC/youth/agriculture/index.html>

^[2] DHHS (NIOSH) Publication Number 2015-104

Ms. Roybal-Allard: The Department of Labor's ILAB child labor programs suffered a \$5 million reduction in the last appropriation's cycle. How are these programs incorporated into ILAB's work to reduce child labor internationally where they have contributed to getting 78 million children out of child labor over the last 15 years and reduced the number of children in hazardous labor by half? What is the monitoring and evaluation process that these programs undergo?

Mr. Perez: ILAB's work on child labor, forced labor and human trafficking issues involves three main areas of focus — (1) policy engagement, (2) research, and (3) support for technical assistance grant projects.

In the area of policy engagement, ILAB assists in the development and implementation of U.S. government policy related to these issues. ILAB engages with other U.S. government agencies, non-governmental organizations, businesses, labor unions, international organizations, foreign governments, and key national actors in countries around the world to promote accelerated action and sustainable efforts to reduce child labor, forced labor and human trafficking.

As part of our research efforts, ILAB publishes the Department of Labor's annual *Findings on the Worst Forms of Child Labor*, a report that documents and assesses the efforts of approximately 140 countries and territories that are recipients of U.S. trade benefits to address child labor. ILAB also releases and regularly updates a *List of Goods Produced by Child Labor and Forced Labor*, which currently includes 136 goods from 74 countries, and a *List of Products Produced by Forced or Indentured Child Labor*, which currently includes 35 products from 26 countries. In addition, ILAB developed and launched a Toolkit for Responsible Businesses to assist companies in developing effective social compliance systems to monitor their production and supply chain for child labor and forced labor. Just this past year, ILAB also launched the U.S. Government's first-ever mobile app and open data on human rights, "Sweat & Toil: Child Labor, Forced Labor, and Human Trafficking Around the World." As a result of our research and reporting, ILAB has been able to raise global awareness of child labor and forced labor issues and used the research as a tool to engage foreign governments and other stakeholders to incentivized action to address these problems.

ILAB is the world's largest funder of projects to combat the worst forms of child labor, adopting a holistic approach to ensure sustainable efforts that address child labor's underlying causes. These technical assistance projects provide children engaged in exploitative labor, or at risk of entering child labor, with education and vocational training. They also provide livelihood services to vulnerable families, as well as training for labor inspectors and law enforcement officials on countries' child labor laws. Between 1995 and 2015 ILAB has funded approximately 300 projects to reduce child labor in over 90 countries, with numerous achievements, including:

- Providing education and vocational training to close to **2 million children**.
- Providing livelihood services to approximately **140,000 vulnerable families**.
- Providing training to at least **50,000 teachers** on child labor issues.
- Training more than **50,000 labor inspectors and law enforcement officials**.
- Supporting child labor and forced labor research, including over **300 surveys, over 90 national child labor surveys, more than 70 research and policy papers and approximately 500 thematic, country, regional and global reports** on child labor.
- Increasing the capacity of about **80 countries** to address child labor and forced labor, including through **new laws and regulations; policies, plans, and programs; and national and local child labor monitoring systems**.

These ILAB technical assistance projects are linked to ILAB's broader efforts to address labor exploitation. They play a key role in building the capacity of local actors in countries where ILAB funds projects and demonstrating effective approaches that can be replicated to improve the situation faced by vulnerable children and their families. Through efforts in each of these areas as well as promoting policies and research aimed at reducing global child labor ILAB has made a significant contribution to the **overall reduction in the number of child laborers** around the world — **a total reduction of 78 million from 2000 to 2012 according to estimates from the International Labor Organization**.

In response to this year's \$5 million reduction in funding for technical assistance programming in this area, ILAB has had to adjust the scope, scale, and number of ILAB's technical assistance grants that address labor exploitation of vulnerable populations such as children among U.S. trading partners. ILAB continues to evaluate and target its resources to priority areas of action where the funds can have the greatest overall impact in support of ILAB's core mission.

ILAB technical assistance projects are monitored and evaluated on a regular basis to ensure that appropriated funds are being used to accomplish project objectives. ILAB uses a variety of monitoring, evaluation, and oversight methods to assess projects' performance, effectiveness, and impact. Each project develops a Comprehensive Monitoring and Evaluation Plan (CMEP) to design and guide the process of managing, monitoring, evaluating, and reporting on project progress toward achieving intended results and outcomes. Under the CMEP, projects develop a set of indicators, and annual and overall targets for each, to monitor progress towards meeting project benchmarks and goals.

Two main types of independent evaluations supplement ongoing performance monitoring to provide more rigorous, in-depth analyses on overall project progress and impact. The main purposes of implementation evaluations are accountability, process improvement, and learning for future projects. Impact

evaluations gather empirical evidence on the impact of selected project interventions on child labor, and provide data for decision-making about which projects to replicate and scale up. ILAB staff routinely reviews progress and financial reports for our projects. ILAB also has a project audit program that conducts external audits of select projects each year, focusing on financial and regulatory compliance and data quality review of performance data.

In addition, ILAB has developed and implemented a strong framework for financial accountability and effective monitoring and evaluation of technical assistance grants prior to and in response to two recent Government Accountability Office (GAO) reports on international labor grants. ILAB concurred with all six of the recommendations contained in the two reports and has since implemented changes such that GAO closed four of the recommendations related to financial and performance monitoring. ILAB has used the recommendations and engagement with GAO to develop additional guidance, practices, processes, and training to address all of the recommendations, and has provided responsive materials to GAO to close out the two outstanding recommendations related to document management.

YOUTHBUILD

Ms. Roybal-Allard: Local YouthBuild programs have a strong track record working with low-income 16-24 year olds who are both out of school and out of work, and are looking to turn their lives around. Please explain how outcomes for local YouthBuild programs have steadily improved over time.

Mr. Perez: The Department of Labor assumed authority for the YouthBuild program in 2006 and first awarded grants in 2007. The performance outcomes for the first complete grant class under DOL's management were 43 percent for placement in employment or education, 61 percent for certificate/degree attainment, and 50 percent for literacy/numeracy gains. Over the last 9 years, the YouthBuild program has made significant performance improvements. With the 2012 grants, the most recent completed grant class, the placement rate was 57 percent, the certificate/degree attainment rate was 77 percent, and the literacy/numeracy gains rate was 67 percent.

The YouthBuild program also has focused on innovative approaches to support improved outcomes, such as the Construction Plus component, which allows successful YouthBuild programs to provide training and certification in in-demand industries beyond construction. Recent data analysis of the Construction Plus component has demonstrated a correlation between programs that use Construction Plus and an increase in placement rates, with Construction Plus programs showing a 10 percent higher placement rate than non-Construction Plus programs. The Department continues to focus on placement efforts, including Technical Assistance that targets Registered Apprenticeship, Construction Plus,

Career Pathways, and Employer Engagement as effective ways to improved outcomes.

The YouthBuild Technical Assistance (TA) model heavily emphasizes performance management for program improvement and provides ongoing training related to data management. Data trends are analyzed to target TA needs and promote best practices. Additionally, the YouthBuild program uses a unique, real-time Web-based case management and reporting system that provides various data analysis tools, including grantee-specific reports to help grantees actively manage their grants and increase their awareness of performance outcomes.

Ms. Roybal-Allard: The Workforce Innovation and Opportunity Act places strong emphasis on work-based learning for both youth and adult dislocated workers. What are best practices demonstrated by programs based off of this model, such as the YouthBuild program, and why is combined education and training a strong federal investment?

Mr. Perez: The YouthBuild program has a strong focus on work-based learning in which participants are actively engaged in vocational training in construction both through classroom training and hands-on training in an active construction worksite. The YouthBuild program is undergoing a rigorous random assignment evaluation and the findings of the first phase — the implementation study — were released in February 2015. Several promising practices for work-based learning emerged from the findings, including a focus on hands-on tasks, the ability to learn practical skills in a “safe” environment, allowing youth to develop leadership skills, and helping youth connect their training to positive impacts on their communities.

Encouraging hands-on learning allows YouthBuild participants to be more engaged and better understand the applicability of the skills being taught in the classroom and on the construction site. Because participants are trained on active construction sites but within the context of an education program, they have the opportunity to learn from their mistakes in a way not always possible on a traditional job site, creating more comfort with the world of work. Participants are also actively encouraged to undertake team leader roles on their construction crews, creating a greater sense of responsibility and helping to develop leadership skills. And because the YouthBuild program requires that youth work on affordable housing, youth are able to clearly see the positive effect their work has on communities, which further grounds the coursework in reality and positive outcomes.

For non-traditional learners in particular, combined education and training can create a level of commitment to the lessons being taught and replaces theoretical aspects of learning with practical approach. Further, by focusing the education on practical skills that will be used on the job, youth may achieve outcomes faster as

they are combining efforts to receive not just education credentials, but also industry-recognized certifications that may lead to career pathway employment.

W I T N E S S E S

	Page
Burwell, Hon. Sylvia	6
Enomoto, Kana	225
Perez, Hon. Thomas E.	300
Spencer, Wendy	188

